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# *the* MODERN HOSPITAL

VOLUME 56

APRIL 1941

NUMBER 4



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ONE of the finest new hospital buildings anywhere in the United States now graces the skyline of Richmond, Va. It is the new central structure for the hospital division of the Medical College of Virginia. Next month we shall describe it.

WOULDN'T you like to have a new x-ray department without a cent of cost? Well, that is almost what happened to the Hurley Hospital at Flint, Mich. The extensive modernization program was paid for entirely from the department's earnings—and in four years.

AS REPORTED in our news this month, the hospital service plans and the A.H.A. trustees have worked out a joint relationship that is mutually satisfactory. This will be analyzed in greater detail in next month's issue.

MANY hospitals are keenly interested in modernizing their buildings and services. The MODERN HOSPITAL has a new feature for these alert institutions. Administrators and their associates will find the eight pages of new products a vital help in keeping abreast. Turn to "What's New for Hospitals," page 153.

## READ AND PASS ALONG

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Administrator		
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Surg. Supervisor		
Dietitian		
Housekeeper		
Pharmacist		
Engineer		
Laundry Manager		
Radiologist		
Pathologist		
Chief of Staff		
Return to		

# The Modern Hospital

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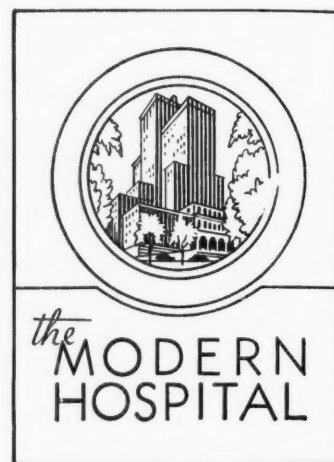
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Vol. 56, No. 4, April 1941

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HOSPITAL





### Baby Picture Parade

• Who is not interested in attractive baby pictures? There could be no question from the very first day that the display of baby pictures appeared in the lobby of Wesley Hospital, Wichita,

No. 3 is devoted to the out-patient department. "Seventy clinics are conducted every week at the out-patient department. This is one of the most important departments of the hospital..." No. 4 takes as its subject the social

ment has a direct effect on the amount of business activity that takes place in Albany..."

No. 9 supplies a few more challenging facts. "Few people realize that in medical centers, such as Albany Hospital, from 55 to 75 per cent of all our patient days represents so-called service cases for which no doctor receives one cent for his services and the hospital receives on the average only about 55 per cent of the actual cost of caring for these patients..."

Each folder is attractively presented, printed on different colored paper with an effective illustration on the front cover. They are handed to patients and visitors and are also mailed to a list of hospital friends serially, which is one convincing illustration of why the community is Albany Hospital minded.

### Buffalo General Serves Tea

• Let's stop in for tea at Buffalo General Hospital, Buffalo, N. Y. It's their invitation. Surely there could be no more attractive place in which to spend a few minutes enjoying tea and cookies than the large solarium on the first floor. If we're fortunate we'll strike an afternoon when the Hammond organ is being played by one of the employees who, incidentally, enjoys quite a reputation as an organist.

"This practice was started about a year and a half ago," Dr. Fraser D. Mooney, superintendent, tells us, and he adds, "we wouldn't think of discontinuing it."

"First, it serves as a nice 'pick-up' at a time when people are tired. Second, it is much appreciated by ambulatory patients, nursing staff, attending staff, house staff, office staff, visitors—in fact, by anyone in the vicinity who happens to drop in for tea with us. Third, from a public relations and personnel relations angle we believe it to be valuable. Fourth, the added efficiency caused by the short rest and tea and cookies, we believe, more than pays for the upkeep—it probably averages between \$400 and \$500 a year."

So don't forget, the invitation stands: tea at Buffalo General every afternoon between 4 and 5 o'clock with the exception of Saturday and Sunday. The average time thus spent is about ten minutes and, believe it or not, the courtesy hasn't been abused—by patients, personnel or public.



One of the groups of baby pictures that cause visitors to Wesley Hospital to gather around and gurgle with admiration and approval.

Kan., that gasps of admiration and delight would be heard from every visitor. Most effective emissaries of good will for the hospital, too, these Wesley Hospital babies, according to Rev. J. E. Lander, superintendent.

### They Tell the Story

• No wonder the Albany Hospital, Albany, N. Y., is daily making more friends and influencing more people. It's that series of little folders called "Albany Hospital Sidelights" that's doing it. Everett Jones, director, believes in talking "hospital" consecutively and persistently—not too much at a time, lest you tire your audience, but enough to keep it interested and to whet its appetite for more.

Each little folder, they measure 4 by 6 inches, contains a message. No. 1 is addressed to the patient—"Albany Hospital, its staff and board of governors extend this greeting to you..."

No. 2 covers history and management. "The first patient was admitted on Nov. 17, 1851. The hospital was the first one established in Albany..."

service department. "This new development in hospital work was inaugurated at Albany Hospital in 1928. It was the first department of its kind in the capital district..."

No. 5 is dedicated to the hospital as a medical center. "Albany Hospital and medical school bring to the patient the more recent discoveries in medical science and the latest methods of diagnosis and of the treatment of disease..."

No. 6 has as its subject emergency service and ambulance calls. "2-4411. The Albany Hospital telephone rings. 'Send an ambulance,' cries an excited voice over the wire..."

No. 7 is all about diet and food service. "Come into the kitchen with us at Albany Hospital. We think you will be interested to see three meals a day for over one thousand persons being arranged and prepared by an especially trained staff..."

No. 8 takes up the commercial value of the hospital to the community. "Few realize that Albany Hospital has 850 employees, more than many of the factories in our city. This large employ-

# This Capsule

## MAY SAVE A BABY'S LIFE

INTRACRANIAL hemorrhage in the newborn, now generally recognized to be the result of the delayed clotting of the blood, which is usually associated with a low prothrombin content, ranks as a primary cause of injury or death. Until recently there has been no known method of prevention.

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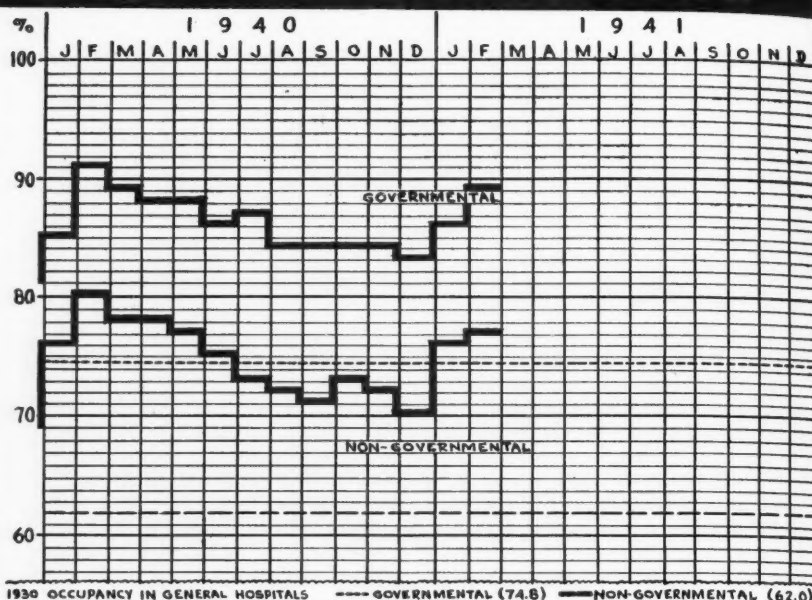
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# HOSPITAL OCCUPANCY BAROMETER

Type and Place	Census Data on Reporting Hospitals		1941		1940	
	Hosp. <sup>1</sup>	Beds <sup>2</sup>	Feb.	Jan.	Feb.	Jan.
<b>Governmental:</b>						
New York City.....	17	10,380	107*	107*	109	101
New Jersey.....	5	2,285	86*	86*	102	99
N. and S. Carolina.....	20	2,655	80*	79	76	77
New Orleans.....	2	3,422	85*	82	77	69
San Francisco.....	3	2,555	110	104	101	98
St. Paul.....	1	850	69*	69	81	62
Chicago.....	2	3,500	89*	92	94	92
Total <sup>4</sup> .....	50	25,347	89*	88*	91	85
<b>Nongovernmental:</b>						
New York City.....	70	16,526	69*	69*	79	75
New Jersey.....	56	8,111	73*	73*	80	75
N. & S. Carolina.....	109	7,913	69*	67	71	71
New Orleans.....	6	1,233	75*	75*	85	82
San Francisco.....	16	3,178	83	80	80	76
St. Paul.....	9	1,134	85*	85	89	78
Chicago.....	26	5,103	78*	73	72	68
Cleveland.....	4	800	83*	83*	85	80
Total <sup>4</sup> .....	296	43,998	77*	76*	80	76

<sup>1</sup>Excluding hospitals for tuberculous and mental patients and institutional hospitals. Census data are for most recent month. <sup>2</sup>Excluding bassinets, usually. <sup>3</sup>General hospitals only. <sup>4</sup>Occupancy totals are unweighted averages. \*Preliminary report. Complete occupancy figures for January 1933 to November 1939 are given on page 1026 of The Nineteenth Hospital Yearbook.



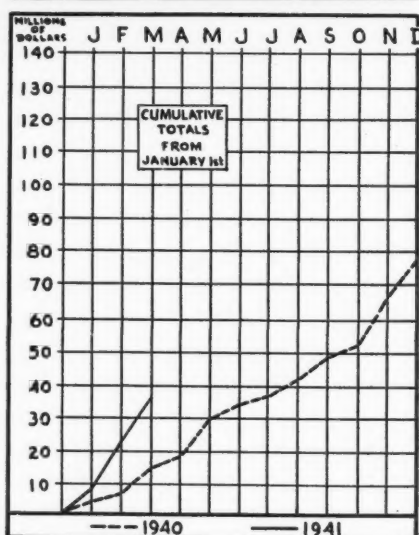
## Record-Breaking Construction Total Reflects Army Activities

Incomplete reports on occupancy in the nongovernmental general hospitals indicate a one point rise in February over the January total but a three point loss as compared with February of last year. There are several areas yet to be reported, however, and these late reports will undoubtedly bring up the total somewhat. In any event, an occupancy of 77 per cent in this large group of hospitals is a very high monthly average.

In the governmental general hospitals, also, the February occupancy is one point above January but two points below the February record of 1940, according to the reports available at time of going to press.

A total of \$13,492,000 of new construction projects reported between February 10 and March 10 brought the total for the year to date to \$36,065,000. This record-breaking total was accounted for in considerable part by the hospitals being built by the United States Army at various army posts throughout the country. Since the first of the year, five large Army general hospitals (of 750 to 2000 beds) have been reported. These five hospitals are to cost \$7,900,000. In addition, there has been a large number of smaller hospitals, most of them of a temporary nature.

### HOSPITAL CONSTRUCTION



The \$36,065,000 in new construction reported in the first three months of 1941 compares with \$14,800,000 last year, \$25,279,000 in 1939 and \$23,052,000 in 1938.

There were 51 new projects first reported last month and four additional projects whose cost was first ascertained last month. Fifteen were hospital buildings to cost \$8,918,816. Eighteen were additions which involved \$4,520,982. There was one alteration

job costing \$22,000 and one nurses' home costing \$30,000.

Prices advanced sharply in the period from February 15 to March 15, according to the indexes of the *New York Journal of Commerce*. The general wholesale price index moved from 82.6 to 84.1. Grain prices went from 64.1 to 67.8, food prices from 70.1 to 71.3, textile costs from 75.6 to 79.4 and fuel from 85.6 to 88.0. The only retreat was a minor one in building material costs, which dropped from 112.8 to 112.4 during this period. (1927-1929 equals 100 per cent).

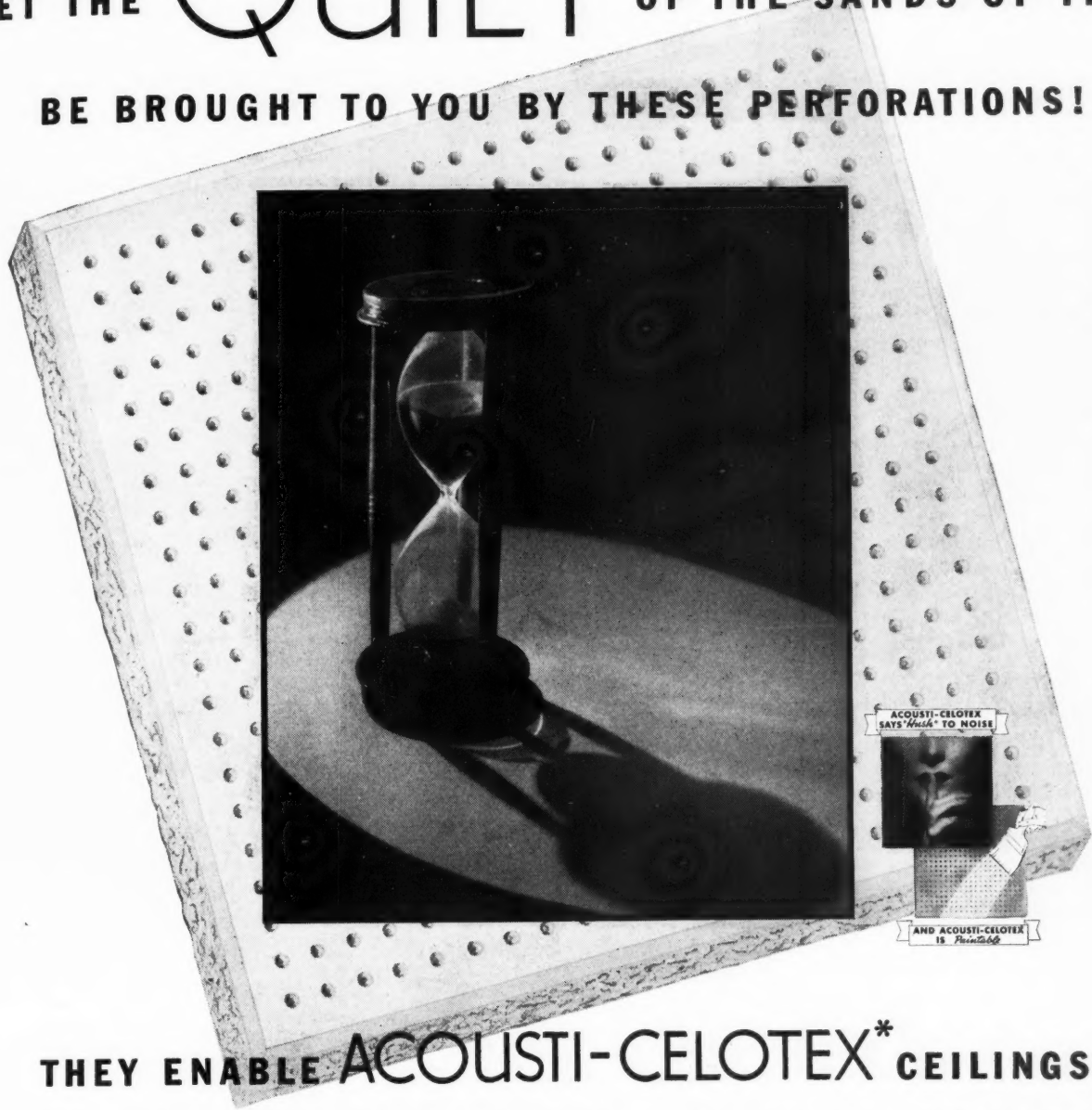
The price index for drugs and fine chemicals as computed by the *Oil, Paint and Drug Reporter* (based on August 1, 1914, as 100 per cent) moved up from 206.6 to 207.3.

The volume of retail trade and real national income reached new peaks in 1940, according to a study just completed by the National Industrial Conference Board. Total retail sales are estimated to have amounted to about \$45.5 billion, as compared with \$42 billion in 1939. The 1940 total, like the 1940 total of realized national income was the largest since 1930. It was only 6 per cent lower than the all-time high of 1929. In 1940, retail trade absorbed 63.3 per cent of the \$71.9 billion of national income.



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# SMALL HOSPITAL QUESTIONS

## Colored Linen in Operating Room

**Question:** We are intending to change the color of our operating room linen from white to green. We have been told that cotton suiting (Indianhead) is suitable. Would this be the best material or would you suggest any other? We also understand that the color must be boilproof; any information regarding the solving of the laundry problem of these colored linens would be greatly appreciated.—Mother Y., N. Y.

**ANSWER:** We have used green linens in our operating rooms for nearly eight years and have found considerable difference in the color supplied by several manufacturers. The gowns we have been using are green cotton suiting. This material has stood up pretty well for a period of a year and has retained a fairly good green color, although it has become somewhat faded.

Some hospitals attempt to dye their own material. We tried this but found we could not get a color that was fast or, at least, one that would retain the color as long as the material dyed by the manufacturers.

The cost is normally 15 or 20 per cent more for the colored materials, but the surgeons feel that the additional cost above the price of white goods is warranted by the reduction in the amount of glare.—H. E. BISHOP.

## Providing Instruments to Staff

**Question:** Should a privately owned hospital provide instruments to staff surgeons?—L.E.D., Va.

**ANSWER:** We believe that a privately owned hospital should provide the use of instruments to staff surgeons, if it extends the use of other property belonging to the hospital. This could be included with the cost of maintenance and could be added to the general costs as part of the hospital equipment.—FRANCES C. LADD.

## How to Obtain Residents

**Question:** Do small hospitals have difficulty in obtaining a resident physician? We have always been able to find a resident until the last year; there seems to be none available now.—H.R., Pa.

**ANSWER:** Small hospitals do have difficulty in obtaining resident physicians. This year the army needs 8000 doctors, a large percentage of whom will be drawn from the group of men normally entering residencies. However, this is only one of the reasons for the present shortage of residents.

Many small hospitals lack facilities for educational pursuits that the good progressive physician now demands in his preparation for special practice. Small hospitals that cannot offer educational

Conducted by Gladys Brandt, R.N., Children's Free Hospital, Louisville, Ky.; Alloys F. Branton, M.D., Willmar Hospital, Willmar, Minn.; Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William J. Donnelly, Princeton Hospital, Princeton, N. J., and others

opportunities to these young men should consider employing salaried house officers. These men should receive an income commensurate with the value of their services. They should not, however, expect educational opportunities that will prepare them for the practice of a specialty.—R. C. BUERKI, M.D.

## Educating Trustees

**Question:** How may we educate small town, hidebound, narrow (male) members of the board of directors who cannot be induced to attend state meetings and who consider the hospital in the same light as a factory?—M.M., N.Y.

**ANSWER:** Case studies should be made of these so-called hidebound, narrow male trustees to see what part of hospital service holds the greatest appeal to them and how their interest may be developed. They must be tough individuals, indeed, who will not respond if properly approached. Give each one something to do, something that will enable him to utilize his business sagacity or professional knowledge. Make him feel that much depends upon him, that he is needed; feed his ego, in other words. And, to make him see the hospital in its true light, present him with a list of suggested reading. If it is possible, arrange informal meetings between hospital trustees of the community, giving each and all a broader slant on hospital affairs.

Before encouraging the trustee's attendance at state meetings, make sure that the program contains features that will be of interest to him. We cannot expect a busy man to waste his time. Also, much harm can be done through engaging the attention of the trustee in matters that do not lie within his province. Give him some personal thought and something to do—then watch him grow.—RAYMOND P. SLOAN.

## Morning Visitors

**Question:** Do most hospitals have morning visiting hours? What is the usual age limit for children visitors? Our age limit is 12 years.—R.P., Wis.

**ANSWER:** The majority of hospitals in our section have morning visiting hours,

from 9 to 11, with the exception of a few of the municipal institutions that allow visitors only one or two hours in the afternoon. Some hospitals do not admit children under 12 in the obstetrical department or nursery. Many place no age limit in the other departments.—JEWELL W. THRASHER.

## Closed or Open Staff?

**Question:** Should we have a closed medical staff in a 70 bed hospital?—P.B., Fla.

**ANSWER:** This question cannot be answered definitely without a careful study of all relevant data. It is generally agreed that a closed staff usually means increased efficiency and usually, though not always, enhanced results within the hospital. If the other doctors, however, are required to treat their patients in their homes or in other institutions with low standards, the net result to the community may actually be a loss. There is great danger, however, that a wide-open hospital of 70 beds will permit work to be done that does not always reflect the highest judgment or technic. As a result, the reputation of the hospital and of its staff may suffer.

Presuming that this 70 bed hospital is in a small center and that many of the doctors in the community are general practitioners, one would be inclined to favor a semi-open type of organization. Let all doctors in good standing in the community be connected with the hospital, either as active or as courtesy members, but have the doctors set up a rigid control over all professional work. Let the doctors be privileged according to their ability; the right to do major surgery without consultation or assistance, for instance, should be strictly limited. Unethical conduct or failure to abide by the hospital regulations should terminate all staff privileges. It places great responsibility upon the leaders in the staff organization but, from the community's viewpoint, as well as that of the hospital, it is well worth while.—G. HARVEY AGNEW, M.D.

## Serving Special Beverages

**Question:** How much of special beverages, such as ginger ale and coca cola, do you serve without making a special charge?—O.M.G., Wis.

**ANSWER:** Ginger ale is served as desired at all times to all patients and without charge. Special mineral water, such as Poland water, is charged to patients. We do not serve coca cola often, as it is not called for. Fruit juices are popular with patients and these are served without charge.—FRANCES C. LADD.

# LOOKING FORWARD

## Wanted — Medical Supplies

MORE than \$135,000 worth of medical, surgical and pharmaceutical supplies have been sent to Great Britain and Greece by the Medical and Surgical Supply Committee of America since its formation last August. The committee is composed of 285 physicians in various leading cities of the United States from coast to coast.

Hospitals, universities, medical societies, hospital supply firms, pharmaceutical houses and individuals have contributed used instruments or supplies or have sent funds with which to purchase new equipment. Through the volunteer services of physicians, nurses and others in New York City, all donated supplies have been carefully inspected to be sure that they are still serviceable. Instruments are reconditioned free of charge when necessary. Surgical instruments that are no longer usable have been melted and the proceeds used to purchase new equipment.

Surgical instruments, surgical dressings, aspirin, sulfathiazol, tetanus antitoxin, heart derivatives, injectable medications, antiseptics, vitamins, tonics, mineral oils, sedatives, catgut and concentrated foods were included in a recent shipment to Greece. Other items needed in Great Britain, Greece, French Equatorial Africa and the Royal Norwegian Convoy Service include blood pressure gauges, sulfanilamide, sulfa-pyridine, quinine (5 gr. tablets), hot water bottles, rubber sheeting, cotton, adhesive, thermometers, iodine resublimed crystals, argyrol crystals, emergency surgical units, equipment for first aid posts, portable midget anesthesia machines, portable x-ray equipment and equipment for the operating rooms of field hospitals.

Hospitals in all parts of the country are searching their instrument cabinets and storage rooms to find equipment that is still useful but no longer actually needed by the hospital. This is sent to the committee at 420 Lexington Avenue, New York City. Women's auxiliaries are presenting pageants, musicals and similar events to raise money that can be forwarded to the committee.

The hospitals of England, particularly those of London, have been terribly punished by bombing attacks.

They need help immediately in their courageous efforts to care for the thousands of sick and wounded civilians and soldiers. A vivid account of the actual effects of bombing on St. Thomas's Hospital, London, appears in a recent issue of the *New Yorker*. The Greeks, too, need our help.

Every hospital in the United States should respond immediately and as generously as possible to the cry for aid sent out by the hard pressed defenders against Nazi aggression.

## Value of Room and Board

UNDER the revised federal income tax laws, hospitals and other employers are required to report the incomes of all employes earning more than \$800 per year. This would be relatively easy to do were it not for the fact that we must include a fair value for whatever maintenance we provide to these employes, unless it is furnished for the convenience of the employer.

Sometimes maintenance is given an arbitrary value. Several years ago when the Chicago Hospital Council was making a study of employes' salaries it valued maintenance as follows: \$10 a month for one meal per day; \$20 a month for two meals; \$30 for three meals; \$10 for room, and \$5 for laundry. This gives a value of \$45 for full maintenance. Average figures of this kind, while highly useful in making a statistical study, are likely to be misleading when applied to one institution only.

If a hospital sets too high a valuation upon its maintenance, this penalizes the employe by making him pay a higher income tax than he should. If the same valuation is also used in computing rates for workmen's compensation insurance, then the hospital's insurance costs too much.

If, on the other hand, the hospital puts too low a value on maintenance, that permits the employe to pay less than his proper share of governmental expenses. Furthermore, when he sees that his total income, including the value of maintenance, is low, he may feel justified in asking for an increase in salary or may be tempted to accept what looks like more remunerative employment elsewhere.



The proper course for those hospitals that provide maintenance is to attempt to ascertain as carefully as possible its true value either in accordance with the cost to the institution or in accordance with the costs of similar food and housing in the particular community. This figure should then be used both in reporting income for tax and in computing insurance rates.

Increasingly, hospitals are tending to avoid this problem by permitting or encouraging their employees to "live out." Some institutions, of course, are so situated that living out would constitute a real hardship to their employees. Even these, however, might well consider the possibility of giving an option to the employees. Why don't we put most employees on a full cash salary? Then let us install a pay cafeteria for all except dietary employees and establish reasonable food prices that just cover the true cost. Let us price our various rooms in accordance with prevailing rates in the community and give most of our employees the option of taking quarters at the hospital or renting them elsewhere. (There are a few employees who will probably be required to live on the premises so that they will be available in case of emergency.)

Such a solution of the problem not only is more democratic in principle but actually results in greater contentment. The room that looked unattractive to the employee when it was assigned to him willy-nilly will look much more liveable after he has scoured the neighborhood in vain trying to find one as good at a comparable price.

## The Rosenwald Gift

IN NOVEMBER 1936 the Julius Rosenwald Fund of Chicago gave to the American Hospital Association a fund of \$100,000 to be used for the development of hospital service plans. At the time of the gift it was announced that the Commission on Hospital Service would be formed to expend the funds for two purposes: (1) to provide advice and consultation to existing plans and those in process of formation regarding actuarial data, benefits, methods of organization, public relations and annual subscription rates and (2) to coordinate the relations of the plans with the medical profession, public welfare departments, state departments of insurance, private insurance companies and hospital administrators.

At the time of the gift there was only a handful of plans and their total enrollment was less than 600,000 members. Today there are 67 approved plans with a total membership of more than 6,000,000 persons. More important than mere numerical growth is the fact that the plans have successfully surmounted serious financial problems without ever reneging in any way upon their promises to subscribers.

Now the plans are so strong that they will soon take over the full financial responsibility for carrying on these activities.

The entire hospital field is grateful to the fund. One would have to search the records of many foundations very carefully before he would find a grant of comparable size that has given as important dividends to as many people.

## Uniform Hospital Accounting

THERE are many advantages to the hospital field in the adoption of a uniform method of hospital accounting. It permits more intelligible comparisons among hospitals as regards their costs of operation. It improves public confidence in hospital financial reports. It assists governmental agencies that are charged with the responsibility of paying public money for hospital service. It aids the trustees and administrator to obtain a proper perspective on their operating costs.

The hospital field as a whole has been a little slow to adopt uniform accounting procedures. In communities in which a central agency helps finance hospitals, more progress has been made. This is noticeable in New York City, Cleveland, the Carolinas and, more recently, Boston.

The excellent work that has been done by the accounting committee of the American Hospital Association will be of maximum benefit to hospitals only if they follow the procedures outlined. It is appropriate and timely, therefore, that the association has arranged at Indiana University an institute for hospital accountants during the coming summer. This institute should attract a large attendance from all parts of the country. Small hospitals, especially, should send their bookkeepers, accountants, business managers or, perhaps, administrators to this institute.

## Time to Build?

MANY hospital administrators are wondering whether now is a good time to add needed new facilities. The existing capacities are insufficient to meet the constantly increasing demand for hospital service. But they are concerned lest governmental priorities and rationing may interfere with obtaining needed equipment.

The government has set up a priority system for aluminum and for some other types of essential raw materials. It probably will become increasingly difficult to obtain certain kinds of stainless metals or other alloys that are used for armaments or are necessary for government construction.

A check with several architects and supply houses indicates that in their opinion now is the time to build if facilities are really needed. Most manufacturers can still accept orders for nearly all kinds of equipment. While there may be some delay in deliveries, the delay is not likely to be serious at the present time. In another year the condition may be a little better but it is more likely to be much worse.

# Fire — It Can Happen Here

JOHN M. STACEY

Administrative Assistant, St. Luke's Hospital, New York City

**D**ESTRUCTIVE and life-threatening fires will inevitably occur in hospitals this year as in every year. In addition to the long list of well-recognized fire hazards, our hospitals now find reason for concern over many newer risks. Among these are anesthetic gases, oil and gasoline, solvents, pyroxylin plastic, the paint spray room and electrical equipment.

In spite of the use of modern fireproof construction in our newer buildings, no administrator is able to boast in regard to fire "it can't happen here." Fires do happen. Every administrator must be aware of his tremendous responsibility for the protection of hospital property and for the safety of each patient and employee. The importance of fire prevention in hospitals and, in the event of a fire, the necessity for ensuring its prompt control cannot be overstressed.

In an effort to face this problem intelligently, St. Luke's Hospital, New York City, has initiated an educational program for its entire personnel. To this end, a "Manual on Fire Precautions and Regulations" has been prepared and distributed to every employee.\* Fire squads have been organized and trained; special courses in fire fighting for the instruction of the personnel are conducted, and periodic fire drills are held.

While many features of our fire prevention plan have been borrowed from the experience of others, both it and the manual are designed to meet the particular conditions in this hospital.

In the manual are directions regarding precautions to be taken by the hospital personnel at the time a fire alarm is sounded. The responsibilities and duties of each department and its personnel are defined and the code rings and locations of hospital fire stations are listed. Each employee is held responsible for a

knowledge of the contents of the fire manual and practical knowledge of what he is to do in case of fire.

Each department head assumes responsibility for instituting fire preventive measures in the sections of the hospital under his jurisdiction. The administration solicits suggestions from them and from their employees for improving its fire protection system. Department heads also make certain that the employees in their respective departments thoroughly understand their duties in case of fire emergency and instruct them in the use of fire-fighting equipment.

Fire drills are held periodically for the purpose of further familiarizing the personnel with the fire emergency routine. A short report of each drill is submitted to the director by the administrative officer in charge of it. The report notes the length of time it took the fire squad to reach the location of the alarm and includes general comments upon the response made by the employees in various departments. Occasionally, a drill is held during the early evening

hours to acquaint the night personnel with the program.

The fire squad is all-important in the work of fire control. The hospital depends upon these selected employees, the speed of their response to an alarm and the efficiency with which they operate to protect precious lives and valuable property. The engineering department is in charge of organizing, training and directing the squad, which is composed primarily of employees from this department. Special courses in fire fighting are conducted for the instruction of these persons and arrangements are made for them to attend a "fire school" for the purpose of learning how to fight fires.

The fire squad responds to each alarm as quickly as possible with extinguishers, axes and fire hooks. The chief engineer or, in his absence, his first assistant, acts as fire chief. To the fire chief also falls the responsibility of determining the necessity of notifying the city fire department. This is always done if there is the slightest doubt as to the ability of the fire squad to extinguish the blaze.

The chief engineer must maintain all of the fire-fighting apparatus in the hospital in perfect working con-



Annual inspections of all fire fighting equipment are made by fire squads.

\*See *The Hospital Yearbook*, Eighteenth edition (1940), p. 951.





The responsibility for examining all fire hose and fittings for possible leaks or flaws devolves upon the engineering department. Gas and oxygen lines and other danger spots must also be checked at regular intervals for leaks.

dition. Soda-acid extinguishers are recharged and all other equipment is examined at least once a year. Gas and oxygen lines, range flues and

other possible fire hazards are inspected periodically by the chief and any irregularities are corrected. Through routine inspections of this

sort, focal points for the occurrence of spontaneous combustion, junk piles that are always fertile grounds for the starting of conflagrations and numerous other hazards are discovered and removed.

When an alarm is sounded, members of the resident medical and nursing staffs report to the wards or floors to which they are regularly assigned where they assist in the closing of windows and doors and, if necessary, in preparations for the care and removal of patients. A definite routine for the removal of patients in an orderly and smooth manner has been established by the director of nursing whose department, in turn, is well instructed in its operation.

In every department all employees on duty are instructed that upon the alarm all doors and windows must be closed and, in special instances, such as the dietary and laboratory departments, preparations must be made for the turning off of gas, electricity and oxygen lines upon orders from the department head or chief engineer.

Naturally, all telephone operators remain at their posts until notified to leave by the administration or fire chief, for it is through the telephone and call system that instructions may, if necessary, be communicated throughout the hospital. At St. Luke's, the emergency is announced over the hospital call system by paging with the words, "calling station 555" and sounding five strokes on the fire gongs that are situated throughout the hospital.

To the patient these words are meaningless, thus preventing undue alarm and excitement, but to the hospital employee this call means "fire alarm" and the standing order to prepare accordingly. The close of a fire drill or emergency is announced through the call system by paging "call to station 555 canceled." It would seem to be fairly feasible for any hospital to work out a similar emergency announcement system adapted to its type of communication medium.

Any responsible administrator must recognize the importance of a well organized and operated program of fire precautions and regulations, for it is only through such a program that the lives of patients and personnel can be safeguarded.

## Preparing Pay Roll by Machine

CHARLES F. WILINSKY, M.D.

Executive Director, Beth Israel Hospital, Boston

THE use of an addressing machine at Beth Israel Hospital, Boston, for the purpose of preparing pay roll lists has been found to be economical as well as advantageous in other ways. Several addressing machines on the market make it possible to print the information desired from previously prepared plates on various pay roll forms. One plate only is necessary for each employee, from which time cards, pay roll lists and pay roll checks can be prepared. The machine can also be used for facsimile signatures on checks.

It is particularly important to emphasize that the addressing machine can serve useful purposes in other essential office work, such as the addressing of envelopes, the preparation of staff lists and the assembling of other data in an expeditious and accurate manner.

Pay roll sheets are prepared for each department by listing on the sheets the names of personnel and rates of reimbursement. About twenty minutes is required to list from 350 to 400 names. Time cards can be run off in about fifteen minutes. In preparing the pay roll checks, the machine prints the name of the employee and the date and enters the rate of pay, as well as the facsimile signature, all in one operating procedure.

One of the most important factors in connection with the use of this equipment is the accuracy of the machine, since, once the plate has been prepared and checked, it is impossible for the machine to print erroneous information. This form of equipment can be highly recommended as an accurate time-saving and labor-saving device.



# Nursing Reserve for Defense

JOHN A. LINDNER

Administrator, Perth Amboy General Hospital, Perth Amboy, N. J.

**B**ECAUSE Perth Amboy is situated in a highly industrialized, strategic area and many of our local plants produce dangerous military supplies, such as nitroglycerine and powder, there is always the possibility of a major catastrophe. In such an event, we might be seriously hampered by lack of nurses and other personnel to care for the injured.

To safeguard the community against this contingency, we have started a course of emergency aid. During 1942 a total of 100 women in the community will be given an intensive four weeks' course that will prepare them to come into the hospital and assist the nurses.

This course is not to be confused with the American Red Cross home nursing program. Nor is it a course in practical nursing. It is a course in emergency nursing under supervision. The women will become familiar with the hospital's physical plant and will receive sufficient training and ward experience to permit them to begin functioning immediately upon call.

## 200 Volunteer for Course

The course is not designed for women who are only passively interested. It requires hard work and conscientious application during the full hundred hours of instruction and experience.

Apparently the women of Perth Amboy and surrounding communities are glad to help the hospital in this way. Already more than 200 of them have volunteered.

The course is to be given by two of our instructors under the direct supervision of the superintendent of nurses, Eleanor C. Tilton. The hundred hours will be divided as follows: theory, ten hours; demonstration, fourteen hours; practice in classroom, admitting office, wards and operating floor, seventy-six hours. The first four week period runs from March 15 to April 12. Seven additional periods are scheduled between April 19 and December 13.

Additional regulations regarding the course have been outlined as follows:

**COST:** A special uniform will be worn during the entire course. These uniforms (two dresses and six aprons) will be provided by the hospital at the expense of the individual candidate and will cost not more than \$10. This is the only expense incurred during the course. White stockings and shoes with rubber heels must be worn. The cost of lunches and laundering of uniforms will be borne by the hospital.

**HOURS:** The hours will be from 9 a.m. to 3 p.m. daily with one hour for lunch, Monday through Friday. No Saturday work is given.

## What Emergency Aids Are Taught

**CONTENTS OF COURSE:** *Saturday Morning Preceding Course:* Physical examination, fitting of uniforms and orientation period, including introduction to the hospital by the administrator.

*First Week:* Tour of the entire hospital and instruction in the functions of a receptionist. Theory, demonstration and practice during this week will include the admission of the patient to the hospital and care of personal possessions as well as the serving of diets, feeding of the patient, bed-making, care of flowers and distribution of mail.

*Second Week:* The different types of bed-making and positions in bed for the safety and comfort of the patient will be demonstrated and practiced. The rendering of assistance to the patient getting out of bed and walking during convalescence is also included.

*Third Week:* Theory, demonstration and practice in giving the patient a bed bath, alcohol massage and cleansing enemas will occupy this week.

*Fourth Week:* The care of an individual during an emergency will be explained by one of the doctors of the staff. Theory and opportunity to observe in the maternity department and operating room will complete the course.

Ample opportunity will be given for observation and practice on the

hospital wards of the procedures demonstrated and practiced in the classroom. Lectures will be given by members of the staff.

**SELECTION OF CANDIDATES:** Owing to the limited resources of the hospital we are able to accept only 10 members in each monthly group; only those considered most suitable will be selected. Those selected from month to month will be notified in ample time so that necessary personal arrangements can be made.

**GENERAL REQUIREMENTS:** We will accept for this course only those who will agree to regular attendance for the entire period. Only in case of extreme emergency will absences be permitted. Each candidate must agree to make her services available for short periods of time in any industrial catastrophe or other emergency that may occur during the five year period following completion of the course.

## Temporary Wards in Churches

It is expected that short periods of emergency service will be given by the emergency aids without pay. If services are required for extended periods, emergency aids will be placed upon a pay status.

Our hospital is overcrowded and incapable of rendering proper assistance in the event of a catastrophe involving a number of people.

Churches and other organizations in the area are being asked to indicate spaces that may be made available in case of catastrophe for use as temporary wards for the care and treatment of the injured. These areas will be carefully studied and, when the study is completed, we expect actually to place emergency supplies at the various points. The supplies will be boxed and inventoried, ready for instant use.

To complete the program a study is also being made of transportation facilities, such as emergency ambulances, police squad cars and other appropriate conveyances, that may be pressed into use for catastrophe service.

# Surgical Supervisor v.

RUTH DANIELSEN, R.N.

**A**POSTOPERATIVE infection is one of the many disagreeable and costly complications that prolong a surgical patient's convalescence. When the infection can be traced to the operating room it is a sad day indeed for the supervisor.

To guard against such a calamity means constant work and watchfulness and careful supervision. The following are the principal factors in postoperative infections: (1) improperly sterilized and, therefore, unsterile, wrapped supplies, (2) improperly sterilized instruments, (3) actual contamination of the sterile supplies or operative field resulting from ignorance of proper technic, carelessness, fear or "droplet infection" from exposure to personnel suffering from respiratory diseases.

Basic teaching of the proper technic is the foundation upon which all of these factors rest. The hospital may be perfectly equipped with all the latest mechanical devices and foolproof machinery but if the human element behind it all is ignorant nothing in the world will keep accidents from happening.

The operating room is usually staffed with graduate nurses, a few student nurses and attendants and orderlies to do the routine and heavy work. The entire personnel needs careful and close supervision in all details of the work it is expected to perform.

It is usually taken for granted that every graduate nurse knows sterile technic. Sad to say, that is not always the case. Every hospital has its own routines and these are usually strange to the new nurse. She should be given a short résumé of the course that the student gets in detail. When the hospital is fortunate enough to have a teaching supervisor the responsibility of giving these classes falls upon her. If no such person is designated on the staff, the surgical supervisor does the teaching herself.

The résumé should include a complete tour through the operating room to acquaint the new nurse with the department in its entirety. Such routines as she will need to know in order to care for the patient before,

during and after the anesthetizing period; the common positions in which the patient may have to be placed, and the mechanisms of the tables and the autoclaves should be gone over immediately. Classes for students should be given in parallel order to the actual experience the student is getting and should be inclusive enough to cover all the routines, as well as their underlying principles.

Attendants and orderlies should be taught exactly what to do and what not to do. When in doubt, they should always ask for help. Most of their work will be done in a supply room where the nurse in charge can easily keep an eye on them. Only those who show definite ability and understanding of their work should ever be allowed to run any of the sterilizing mechanisms, such as autoclaves and stills, and then only under constant supervision. All the staff should be watched until the supervisor is perfectly sure that they are able to do the work correctly.

One can do wonders with an efficient, technic-conscious staff even with very little in the way of mechanical help. However, good equip-

ment, properly run, is a tremendous advantage in preventing infections. Surgical equipment, like everything else in this world, eventually becomes outdated and worn out. Replacement of such equipment usually means the introduction of new routines. It is an extremely important part of the supervisor's work to see that these new routines are thoroughly analyzed and made as simple and workable as possible. The simpler the routine, the less chance there is of making a mistake.

Every member of the operating room staff must be shown the new equipment and must have a demonstration. This is an important point. In an emergency, no doctor will willingly try to do a transfusion with equipment he has never seen before. Nor would he like to do the procedure with a nurse assistant who had never helped with one before. Demonstrations followed by supervised work are vital. All routines should be carefully written out and placed in a routine book for reference and study. This book should be kept in some spot that is readily available and should never be allowed to leave the surgery floor.



Proper sterilization of surgical instruments is vital to aseptic technic.



# Postoperative Infection

Supervisor of Operating Rooms, Barnes Hospital, St. Louis

Most surgeons probably agree that autoclaving is the best means of sterilization wherever possible. Every nurse and auxiliary worker who help with the autoclaving of supplies should know the principles of sterilization. They should know the temperature (240° F.), the pressure (20 pounds) and the time (from thirty to forty minutes) needed for the autoclaving of large bundles and drums. They should know that pressure will indicate temperature only if

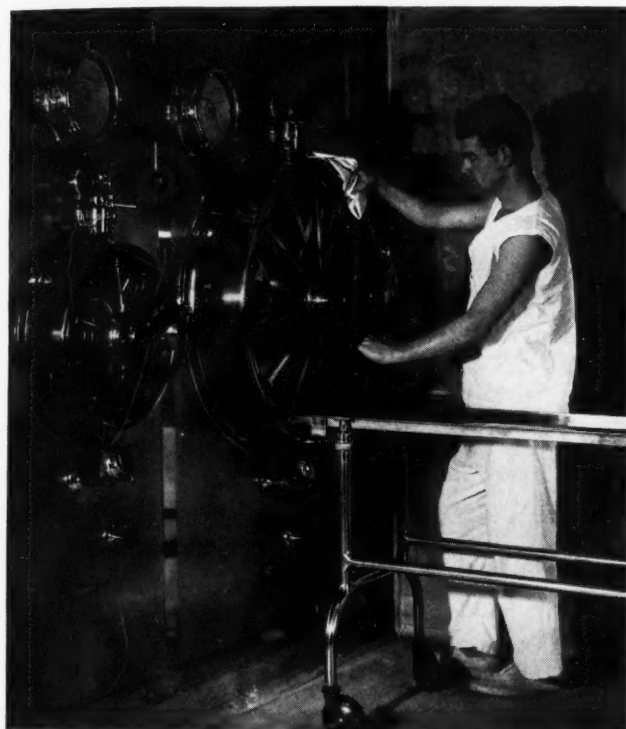
A great many hospitals sterilize all instruments by boiling. Here, again, careful supervision must be carried out to see that the time limit is not cut. If the instruments are to boil twenty minutes, they must remain in the boiling water for twenty minutes and not be removed at the end of five minutes because the nurse forgot to put them in on time.

The timing on all sterilization is important. However, probably owing to the ease with which articles may

be removed from water sterilizers, there are likely to be more breaks in this technic than in others. One definite rule must be made as to which timepiece shall be used in the timing. Some operating rooms use time clocks that can be set and will ring at the end of the required time. Again, sand glasses may be used or the electric clock on the operating room wall. If the individual wrist watches of the nurses are used, only the nurse who starts the sterilizer should be allowed to run it down.

Sharp instruments, such as scissors and knives, cause a great deal of worry and comment. If they are boiled or autoclaved there is no doubt about their sterility but there is a great deal of doubt about their sharpness. If they are soaked in the solution of the surgeon's choice, there is always room to speculate as to whether the instruments are sterile or not. At this point it is always to the supervisor's advantage to cooperate closely with the laboratory in order to get all the latest reports available on the various solutions used.

For cystoscopic and bronchoscopic instruments, formalin sterilizers are probably the most satisfactory. Small electric generators placed in the instrument cupboards have increased the effectiveness of this procedure.



Left: All sterilizing equipment should be checked routinely by the mechanical department of the hospital to make sure that sterility is really being attained. Below: A surgeon completes the scrub-up by rinsing hands and arms in alcohol.

all air is exhausted; that vacuum must be drawn regardless of the need for haste; that solutions are sterilized by boiling and not by steam penetration and should not be subjected to vacuum on being run down in order to prevent them from blowing up; that all ointments, even when they are wrapped, should be placed in the autoclave in such a way that they will not spill and contaminate other supplies. They should also know that rubber goods, especially gloves, need extra care while being autoclaved to prevent them from losing their elasticity and becoming rotten.





To make sure that sterility is actually being attained, cultures should be taken frequently. The mechanical department of the hospital should check all autoclaves routinely and keep them up to the maximum level of efficiency. It is a good idea to keep literature on all types of sterilization on hand for the staff to read.

All of this discussion may be considered the "backstage" working of the operating room. If there is any flaw in it, it is bound to show up somewhere during the operation or in the subsequent convalescence of the patient.

Should an infection occur the supervisor must immediately sit down and analyze the whole procedure. Granted that the "backstage" work was faultless, she must go through the operating routine in the room from which the infection came.

#### **Duties of Circulating Nurse**

In charge of the room is the nurse who usually handles the duties of the circulating nurse. She may be classed as a head nurse and her technic should be above reproach. She knows her routines and her doctors, their likes and dislikes, and how to cater to them most efficiently. All of this she must impart to the nurses helping her. She is responsible for the small items that the supervisor in a large operating room is unable to check personally.

The setting up of the scrubroom seems a trivial matter but, if it is incompletely done one moment of stress is all that is necessary to change a pleasant surgeon to one made up of a bundle of unpleasant nerves. The nurse's temperament will often set the pace for the whole operating team. If she is able to keep herself calm, efficient and pleasant, the whole room will breathe a calm atmosphere that is conducive to good work.

The scrub nurse, who is often a student, needs this calm guidance more than anyone else. Under such supervision her work will seem easier and the qualms of fear that assail all students will gradually give way to a feeling of confidence and joy in being able to do the work correctly. The student should already know the basic technic and now she is ready to pick up the finer points.

The student nurse must know her table, her sutures and her operation

in order to give the doctors the help they expect in the most efficient and unobtrusive manner. If she knows her work, she will not be overcome with panic the first time the surgeon speaks to her. At all times students should be carefully watched and not allowed to scrub except under the supervision of a graduate nurse until they have shown that they are able to take care of a case. The nurse who helps with the position of the patient and the preparation of the skin should be impressed with the importance of doing this carefully and conscientiously.

Throughout the whole operation every nurse should be on the alert for any accidental contamination of any part of the operative field or of any of the members of the operative team. In the summer months, the surgeons must be watched carefully for perspiration and their faces should be wiped as often as necessary. This necessitates a technic all of its own and should be carefully learned. Insects of all kinds may penetrate into the inner sanctum of the operating room and must be dealt with immediately and harshly. Any contamination must be reported immediately to the surgeon so that he may take the necessary steps.

Too often, the doctor or the nurse who happens to be unfortunate enough to catch something (usually a cold) feels that it is his duty to suffer in silence and to work on as if nothing is the matter. It is up to the supervisor to send home members of her staff who appear in the morning with the sniffles.

Colds are most dangerous during the first few days and should be treated accordingly. Organisms of all kinds are breathed out normally in large quantities. To guard against this possible source of infection, masks covering the nose and mouth are worn by everyone who is working in the operating room during an operation. The increase in the number of organisms spread by one person suffering from a cold is so tremendous that a mask cannot adequately guard the patient from infection. For that reason, he should not work in an operating room. This also applies to the auxiliary workers who handle a great many of the supplies and come in close contact with sterile, as well as unsterile, bundles.

Droplet infections are far too dangerous to be dealt with casually and any supervisor with the safety of her patients at heart will see to it that no person who is a potential source of such infections will enter the operating room suite. A definite rule about upper respiratory infections and their control must be made and kept to the minutest detail.

When the operation is over and the patient safely back in bed, the cleaning up process begins. Here, again, careful supervision is necessary. Instruments must be washed and autoclaved. The linen must be sorted and cared for. The whole room must be cleaned up and made ready for another case, if necessary, or for the next day's work, if it happens to be the end of the day.

Extreme care must be taken in going from one case to the next to prevent the possibility of cross-infection. In a well-organized operating room, the time between cases may be only a few minutes, which means that a great deal of work has to be done in a short time. But it never pays to take short cuts with sterile technic. One slip is all that is necessary to ruin the hours of work the surgeon has spent on the patient.

#### **Sterilizing Can Be Overdone**

The fact that any of these procedures may be overdone must also be considered. Autoclaving linen for from thirty to forty-five minutes is necessary for its sterilization, but autoclaving it for one or two hours or longer is definitely harmful to the linen and nothing is gained by the extra exposure to the steam. If it takes that long for the controls to change color, there is something mechanically wrong with the autoclave that should be remedied. Rubber goods will be a complete loss if autoclaved that length of time. Instruments will become rusty if allowed to remain too long in some solutions.

Too much stress on unimportant details of operating room routines will make students lose sight of the real reason behind it all—the patient we are trying to help. The relationship of each piece of work to the next must be shown in a clear way. This correlation of an intricate pattern, the division of work and the supervision of it, all make for a smooth-running department in which accidents are rare occurrences.

# Hail to House Staff Manual

PHILLIP L. ROSSMAN, M.D.

Assistant Resident in Medicine, City Hospital, Cleveland

IT HAD been the practice for years at Cleveland City Hospital to hand down by word of mouth from senior house officers to interns the various rules and regulations concerning the inner workings of the hospital.

Frequently, the rarely encountered procedures were omitted in these instructions. The rest of the rules were usually promptly forgotten owing to the mass of material that flooded the new interns during the early days of their service. Scattered throughout various departments were occasional lists of instructions that were not readily available at all times.

As a result, the first few weeks in July of each year were filled with needless confusion resulting in dissatisfaction to the permanent personnel, patients, relatives and interns. The interns were forced to learn purely administrative details by the painfully cumbersome process of trial and error or by asking questions at every turn. Thus, nursing and medical care, laboratory procedures and administrative detail were all more or less handicapped, depending on the ingenuity and resourcefulness of the personnel involved.

A house staff manual was compiled to obviate this grievous fault. The cooperation of senior house officers, professional staff, nurses and administrative personnel was sought so that the information would be as complete as possible. The manual was sent to each new intern one month before he reported for duty. A copy of the manual was also placed on each hospital division for ready reference.

A subsequent survey of the new doctors revealed that they were pleased to receive the manual and that, after reading it, they felt more confident and capable of undertaking their internship. The nurses remarked that the expected confusion on the wards was at a minimum never before experienced. The secretaries, information office, telephone operators and laboratory technicians all noticed the improvement.

An outline is herewith presented as a framework on which a house staff manual can be built. The size

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**As a measure for the prevention of cruelty to interns—to say nothing of patients, nurses and the senior staff members—Cleveland Hospital recommends the house staff manual which serves to acquaint the intern with the regulations of the hospital**

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and contents of such a manual will, of course, depend upon the individual hospital. The booklet should be so compiled that it can be changed easily from year to year as it becomes necessary.

**1. General Statement:** A brief summary as to the physical setup of the hospital, its history and progress is presented. This may include information as to the hospital ownership, financing, teaching affiliations and the visiting professional staff.

**2. Interns' Assignment Schedule:** This outline informs the interns of their rotation schedule for the year. Each intern has an assignment number on this schedule so that it does not have to be revised each year.

**3. Rules and Regulations for House Staff:** This chapter describes the organization of the house physicians and outlines their duties, responsibilities and professional conduct. The telephone service and call system, as well as the use of hospital equipment, recreation rooms, dining rooms, resident quarters and laundry, are explained.

**4. Routine Work:** The method of admitting new patients and instructions on keeping medical records and progress notes are given. The method of discharging patients and details of the record room also are mentioned. The importance of dating and signing records is emphasized.

**5. Writing Orders:** Herein are listed regulations as to diets, fluids, medications, isolation technic, ward procedures, position of patients and privileges in regard to the use of wheel chairs and bathroom facilities.

**6. Abbreviations:** The use of abbreviations on hospital records is to be discouraged. However, the need for economical use of time and space has lead to this practice, which is acceptable only insofar as standard abbreviations are used. Acceptable abbreviations are listed to avoid misinterpretation and confusion.

**7. Hospital Details:** Questions regarding blood donors, operation and amputation permits, releases, accidents to patients, night regulations and special nurses are considered.

**8. Pharmacy:** Narcotic regulations and rules for prescription writing are given. The hospital formulary may be included under this heading or may be published as a separate booklet.

**9. Observation Ward:** The use of this ward for twenty-four hour observation cases is described.

**10. Hospital Visiting Hours:** The doctors are informed as to their interviews with relatives, the use of special visiting passes for patients in critical condition, the question of privileged communication and the necessity of referring insurance and legal papers to the proper authority.

**11. Deaths:** This important subject is treated in detail with reference to the death of patients, the death certificate and the manner of burial—city or private. The disposal of stillborn fetuses, unclaimed bodies and of bodies of patients who died of communicable diseases is explained. The types of cases that necessitate a coroner's investigation are listed. The old age pension assistance service is discussed in relation to burial and necropsy permits. The necropsy permit is discussed in regard to the method of interview, reasons for doing necropsies, religious aspects and also as to who is legally responsible to sign the permit.



**12. Out-Patient Department:** Details of procedures in the dispensary in regard to medical records, hospital admissions, consultations, laboratory work, legal papers and x-rays are mentioned.

**13. Medical Social Service Department:** Hospital physicians, especially in large charitable institutions, frequently require the help of a social service worker in the treatment, rehabilitation and follow-up study of patients. The use of this service is outlined. This section includes a description of the type of patient who is eligible for care at a city hospital from the standpoint of residence and ability to pay. It also describes briefly the social agencies offering care in the community.

**14. Medical Library:** Library hours and regulations concerning the withdrawal of books are mentioned.

**15. Reportable Diseases:** Diseases that are considered dangerous to the public health are listed so that proper notification to the board of health may be made.

**16. Occupational Diseases:** Diseases that are considered occupational diseases and are compensable as such, according to the workmen's compensation laws of the state, are listed and the method of making official reports is described.

**17. Appointments:** The hospital training of interns and residents is described and the method of application for appointments is given.

**18. Laboratory Procedures:** Detailed instructions are given for the collection and care of specimens for laboratory examination.

This house staff manual has been limited to general hospital details which are of a more or less perma-

nent nature. Clarity of thought was the keynote. In spite of our efforts to be concise the finished manual consisted of 52 pages, 8½ by 11 inches, typewritten on one side and single spaced. The manual is carefully indexed so that desired information is easily available. Each of the various hospital services has been urged to compile a departmental manual that is distributed to the interns as they change services. Some hospitals also have a procedure manual which includes instructions on how to perform laboratory and clinical tests.

It is important that the manual be sent to the new interns at least a month before they report for duty. At that time their interest is high and they have time to read and study the numerous details and procedures that they will be expected to know.

## After the Sanatorium, What?

LEOPOLD BRAHDY, M.D.

HOSPITAL administrators should have a clear concept of their share in the responsibility of rehabilitating former tuberculosis patients, especially their own former employees. The workmen's compensation laws in several states require hospitals to pay part salary to their employes who have acquired tuberculosis in the course of their occupation until they are restored to full earning capacity. Whether a hospital pays this "compensation" directly or is insured does not change the fact that the hospitals in these states now have a financial interest, in addition to a humanitarian desire and a professional duty, in getting employes back to work after they are cured. It now costs money not to understand or not to act.

Tuberculosis patients after many months at sanatoriums are discharged from medical care. The discharge is accompanied with the welcome words: "You may resume work." Then follows a dash of cold water: "But at first you must work at an easier pace or else not the full day!"

Doctor Brahdý is physician in charge of the division of occupational diseases and injuries of municipal employes, New York City.

Some sanatoriums—Trudeau, for example—give the doctors and nurses who are treated there a good start toward resumption of normal life. They do professional work in the sanatorium two or three hours a day during the last few months of their convalescence. Whether or not they have this preliminary retraining these doctors, nurses and attendants face the same difficult problem that all former tuberculosis patients face—to find a job where they can "go easy" the first months or to work part-time until it is safe for them to get into full harness.

There is actually no such thing as "doing something else temporarily" as a substitute for returning to one's usual working capacity. The former patient must resume his natural life, which means working at his own trade or profession and being paid for it.

As far as doctors, nurses and attendants are concerned only hospitals can give them work at their own occupation. This phase of rehabilitation is as much a part of the medical care of a patient as a diathermy application or an operation. Because the hospital is an institution for the

care of the sick, it should welcome the opportunity to serve in this way. Considerations of administrative efficiency limit the number of such patients who can be employed at one time but under all circumstances that number is greater than that of the hospital's own former employes who want such jobs.

What is the effect when a hospital at which he was formerly employed refuses to fit the former patient into its staff?

1. Another tuberculosis victim remains half cured in that his earning capacity is never regained; he loses his morale and is in danger of becoming a neurotic.

2. An experienced person who, because the hospital is a haven of employment for him, would have become a useful and loyal worker is lost to the institution.

3. If the case is covered by the compensation law, the hospital will continue to pay part salary for no return when it could buy much useful service for whatever the market value may be. As long as the patient is not rehabilitated this compensation continues—unwanted by the recipient and a liability to the hospital.

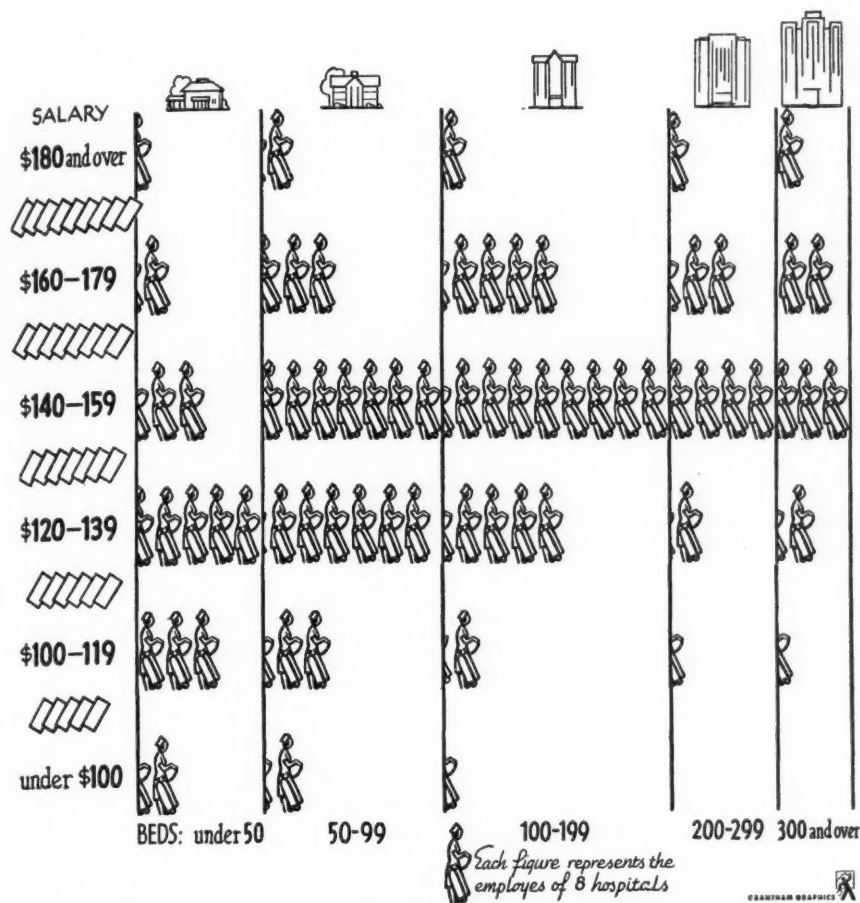
To lose an opportunity to rehabilitate these patients is expensive for the hospital.



# Nurse Anesthetists

## A National Study of Salaries

ALDEN B. MILLS



Nearly 50 per cent of the reporting hospitals employ nurse anesthetists.

NURSE anesthetists in the United States receive an average salary, including the fair value of maintenance, of \$142 per month, according to figures reported by 554 hospitals to The MODERN HOSPITAL's second salary study.

Only five hospitals in Canada reported salaries for nurse anesthetists. Apparently, anesthetics are given almost exclusively by physicians in Canada. This is undoubtedly due to the legal decisions that have held that nurses are not empowered to give anesthetics in the Dominion.

Of the 1171 hospitals in the United States giving reports on salaries that could be tabulated, 549 reported salaries for nurse anesthetists. Apparently, therefore, nearly 50 per cent of the hospitals in this country use nurses for the administration of anesthetics.

The percentage of reporting hospitals that use nurse anesthetists (or,

at least, that reported salaries for them) varied by size of hospital as follows: under 25 beds, 23 per cent; from 25 to 49 beds, 32 per cent; from 50 to 99 beds, 49 per cent; from 100 to 199 beds, 69 per cent; from 200 to 299 beds, 71 per cent; from 300 to 499 beds, 53 per cent, and 500 beds and over, 57 per cent.

It is apparent, therefore, that the nurse anesthetist has the strongest position in the hospitals of from 50

to 300 beds. Most of the hospitals of less than 50 beds combine this work with that of the surgical supervisor or some other employee. In some cases they allow general practitioners to give the anesthetics. In the hospitals of more than 300 beds, a majority employ nurse anesthetists but the percentage is lower than in the somewhat smaller hospitals. Of course, in some of the large hospitals both medical and nurse anesthetists will be employed.

The average salary of nurse anesthetists varies according to the size of the hospital from a minimum of \$116 in hospitals of less than 25 beds to a maximum of \$154 in hospitals of from 300 to 499 beds. This is clearly indicated in the accompanying table of salaries.

The geographic variation in salaries of anesthetists is relatively slight, average regional figures varying only from \$139 to \$147. The eastern area (embracing the New England and Middle Atlantic states) is highest in two classes of hospitals, those under 25 beds and those of from 100 to 199 beds.

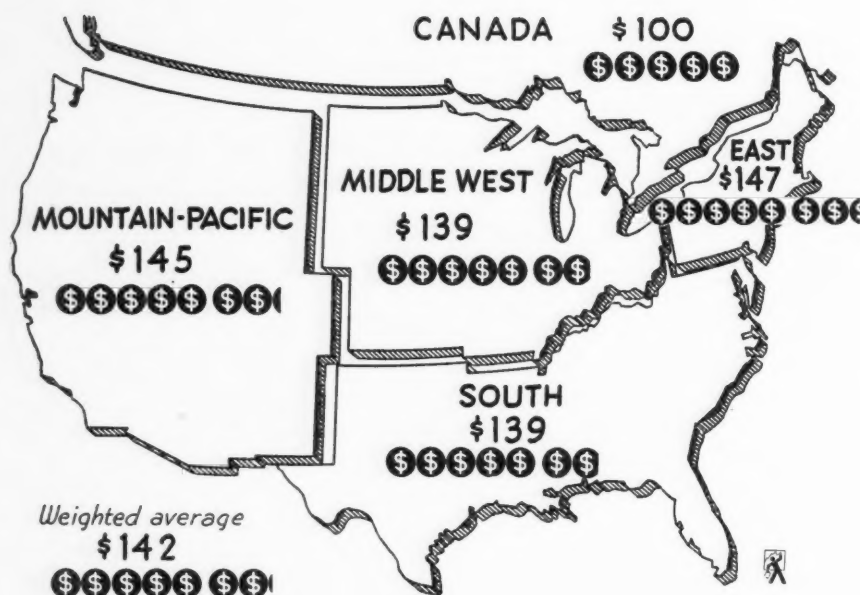
The Mountain and Pacific states are highest in four classes: from 25 to 49 beds, from 200 to 299 beds, from 300 to 499 beds and 500 beds and over. In the hospitals of from 50 to 99 beds the same average salaries are paid in the Eastern, the Southern and the Mountain and Pacific regions. The Middle West has the dubious distinction of being lowest in four classes and tied with the South for low position in two

Average Monthly Salaries of Nurse Anesthetists

Area	Bed Capacity of Hospitals							Total
	Under 25	25-49	50-99	100-199	200-299	300-499	500 and Over	
East.....	\$135 <sup>1</sup>	\$132	\$139	\$150	\$153	\$160	\$155	\$147
Middle West.....	120	124	137	147	145	144	147	139
South.....	111	131	139	142	153	151	147 <sup>2</sup>	139
Mountain-Pacific.....	132 <sup>2</sup>	146	139	145	158	162	161 <sup>2</sup>	145
Canada.....	60 <sup>1</sup>	92 <sup>2</sup>	—	—	—	127 <sup>2</sup>	—	100
Total.....	116	130	139	147	151	154	153	142

<sup>1</sup> Only one report received.

<sup>2</sup> Only two reports received.



Two hospitals pay salaries of less than \$50; nine pay more than \$200.

other classes. The actual amount of the difference, however, is small.

It is interesting to compare the salaries of nurse anesthetists with

other hospital salaries. For superintendents of nurses, the average salaries were as follows: under 25 beds, \$116; from 25 to 49 beds, \$139; from

50 to 99 beds, \$158; from 100 to 199 beds, \$190; from 200 to 299 beds, \$234; from 300 to 499 beds, \$266, and 500 beds and over, \$315. Thus nurse anesthetists receive almost as much as superintendents of nurses in hospitals under 50 beds. As the hospitals increase in size, however, the spread between the salaries also increases.

For nursing supervisors, the average salaries in hospitals of the same classes are as follows: \$113, \$116, \$123, \$134, \$138, \$157 and \$173. The nurse anesthetist receives more, on the average, than the supervisor in all hospitals of less than 300 beds.

In 1935 the American Association of Nurse Anesthetists published a curriculum for schools of anesthesia outlining the requirements for admission, organization and course of study advocated by the association. At present, it is being revised.

Standards for active membership in the association require an applicant to be a graduate of an accredited school of nursing, registered in her state and a graduate of a school of anesthesia that is recognized by the association and gives not less than a six months' course. Nurses who have had six years' experience in anesthesia in approved hospitals prior to 1939 are eligible for membership even though they are not graduates of approved schools of anesthesia.

Two years ago when the association sent a questionnaire to schools of anesthesia, 42 schools were discovered that were giving a six months' course. Many of the schools are now lengthening their courses to eight or nine months and in several the course is twelve months. A one year course is advocated by the educational committee.

A committee of the association, under the chairmanship of Agatha Hodges, is at work on educational standards and plans have been completed for a series of visits to schools of anesthesia. The information obtained will be used to further the development of the program.

The questionnaires on which this study is based were mailed on Dec. 9, 1940, and answers were, therefore, made out in December and January. There is now such a shortage of qualified nurse anesthetists that even in the short period since these questionnaires were filled out there may have been further upward revisions of salaries.

## Principles of Budget-Making

E. M. BLUESTONE, M.D.

Director, Montefiore Hospital, New York City

**B**UDGET-MAKING in the hospital differs from budget-making in the individual case only in extent, variety and complexity of the items that are entered on both sides of the ledger.

There are many factors that the hospital administrator must take into account in the preparation of his tentative budget for the new year. In normal times it is relatively easy to foresee the needs of the institution for a brief twelvemonth. In times like these, however, when no one can be sure whether enough dollars will be available and what these dollars will buy, the task becomes more difficult, if not impossible. Whatever the habits of the hospital administrator may be in normal times, he is a wise budget-maker who shares the responsibility with his board of trustees and with the best thinkers on the subject in the community. This aspect of budget-making has not yet been adequately exploited by the public relations expert, who has recently made his appearance as a member of the modern hospital staff.

Tentative budgets are of two kinds, according to whether the administration is optimistic or pessimistic about the outlook for the year under consideration. In the former case the budget will be liberal on the expenditure side because liberality is expected on the income side. In the latter case the budget will be conservative on the expenditure side because conservatism is expected on the income side. The net result, which may or may not be expressed in terms of an operating deficit, will mark the budget-maker as a good prophet or otherwise.

No one should expect the impossible of the budget-maker, particularly in hard times. His philanthropic relationship to the patients that are entrusted to his care is clear and unescapable. It is for the community to do the rest and this must be done with a full understanding of the difficulties that beset the hospital administrator and the board of trustees. And the public relations executive should see to it that this difficulty is minimized.

# Emphasis on Service

## In the Small Hospital Laboratory

J. T. MORRISON, M.D.

Commonwealth Fund, New York City

THE American College of Surgeons, in its minimum requirements, suggests that the clinical laboratory operate under medical supervision. In a small community hospital with an open staff it may be difficult to find a medical supervisor, but there are two methods by which this may be achieved. If the pathologist employed by the hospital is close enough to make occasional visits, he may well be appointed as the laboratory supervisor and, in that case, should be expected to attend all staff meetings so that he will be available for discussion of laboratory service. However, it is not always possible to make such an arrangement.

The next possibility, therefore, is part-time employment of some member of the staff to do this work. This also presents difficulties as there is not always a physician on the staff who is sufficiently interested in laboratory work to study its use in more detail than is customary for general practice, but there have been instances where such a man has been available.

In several cases with which I am familiar the staff and the trustees selected as supervisor one of the younger physicians, recently graduated from school, who, after his selection, spent some time in residence at a well-developed laboratory in order to familiarize himself with the methods of making the laboratory of most value to the staff and, therefore, to the patients. For the sake of clarity, let me quote the duties outlined for the laboratory supervisor at one institution.

### *Technical Supervision:*

1. Maintain accurate standardization of all materials, reagents, tests and reports.
2. See to it that the methods employed are so carried out that the results are absolutely accurate and dependable.
3. Supervise proper collection, preservation and examination of specimens.

Presented at the New England Hospital Institute, September 1940.

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### **Doctor Morrison concludes his statement of the objectives of the small hospital laboratory and the methods by which these goals can ultimately be reached**

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4. Ensure economy of time, labor and material.

### *Educational Requirements:*

1. Keep abreast of new developments in clinical pathology and pass on the applicability and value of new procedures to the staff.
2. Interpret and correlate at staff meeting the less familiar or new laboratory procedures as related to cases at hand.
3. Present and interpret gross and microscopic specimens.

### *Supervision and Consultation:*

1. Make daily visit to check on work done in the laboratory.
2. Be available at all times for consultation.
3. Be available on request to present clinical pathological work on cases presented at staff meeting.

### *Relationships With Committee:*

1. Assist standards and records committee in revising and promoting minimum routines as already established.
2. Assist in development of minimum routines for certain definite types of cases, such as cardiac, nephritic, diabetic and gall bladder.
3. Make available graphic representations of various laboratory results, such as sedimentation charts and icteric index.
4. Make available chart of normal values as related to laboratory procedures.

These principles coincide with my own ideas on the subject and have been applied by several hospitals I have in mind. In every case the institution has employed such a supervisor for a nominal salary, giving him the responsibility for the work of the laboratory, its accuracy and its scope.

The supervisor is available for consultation both to the laboratory technician and to the staff regarding the best use of the laboratory. He is responsible for the performance of all necropsies, making the study of the gross anatomy for which his additional training has particularly equipped him and working in close cooperation with the pathologist who makes the microscopic examination of tissues. The supervisor is present at all staff meetings and, in participating in the discussion of patient records, lays particular emphasis on the use of the laboratory.

In each of the institutions in question, one of the first tasks that the laboratory supervisor has set for himself has been to devise methods of making the laboratory examinations most understandable to the staff. At one hospital examinations are reported on special forms devised by the pathologist who has given freely of his time and energy to the development of the laboratory. These forms show typical reports of normal and pathologic findings in comparison with the actual report from the hospital laboratory.

Let us turn to the part played by the medical staff as a group in the development of laboratory service. A committee from the staff was appointed to consider the use of the laboratory as a diagnostic aid and to set up minimum standards of diagnostic practice. The laboratory supervisor participated in the work of the committee.

These minimum standards are variously called "routine procedures"



or "standing orders" but, since they apply to specific disease conditions, they are, in effect, minimum standards. The work of the committee was considered by the staff as a group, passed and sent to the trustees for official adoption.

What is a minimum standard? I have at various times defined it as a minimum diagnostic work-up for any one patient considered adequate by authorities for the disease condition diagnosed. I think, however, it can best be defined by an illustration. Let us say that a patient is sent to the hospital with an admission diagnosis of pneumonia. The hospital's standard requires a complete blood count, a urinalysis and a Kahn test. These examinations are made automatically.

The minimum standard as set by the staff requires not only the recording of certain information on the history and physical examination but an x-ray examination of the chest, a typing of the sputum for possible serum therapy and a blood culture to determine the presence of circulating organisms and their identity. These are also obtained automatically unless the physician attending the patient countermands the order.

#### **Routine Laboratory Examinations**

Then, as therapy is begun, certain laboratory examinations are made routinely to follow the course of the treatment and certain nursing practices are followed. The laboratory tests include: (1) blood culture and pneumococcus typing on admission before sulfapyridine or serum therapy; (2) daily determinations of sulfapyridine content of blood beginning 48 hours after first administration of drug; (3) hemoglobin and differential count daily; (4) daily urine examinations for blood and albumin.

Examinations other than those listed here may, of course, be obtained if they are deemed necessary but these have been set as a minimum standard.

The hospital has set up similar minimum standards for the various disease conditions. This required considerable thought and analysis on the part of the staff committee and other staff members, as well as the cooperation of the superintendent, laboratory technician and laboratory

supervisor. There has been a common interest in devising methods for the study of disease conditions and for the use of the laboratory in such studies.

In other words, the spirit and method have been united not only to provide a complete laboratory service for patients, but to set standards to ensure the most efficient use of that laboratory as a diagnostic service and at the same time to make it of value to the staff and worthy of a "teaching" hospital.

#### **Monthly Report Required**

A still further step toward the goal of quality is the development of the monthly report required by the staff that set up these minimum standards. The clinical records of patients discharged during the month are examined by the medical record librarian and balanced against the minimum standard for each condition as it is set up. A record is then made of the percentage of case records that measure up to the minimum standard.

Patients' records brought to staff meeting for discussion, either because of mortality or because of complications, are examined to determine whether the minimum standard was followed and are so reported to the staff and to the hospital administration. The report prepared each month presents the question of compliance with the standard routine in terms of percentages rather than in terms of the individual physician's record.

I have said nothing as yet in regard to keeping records in the laboratory and preparing monthly reports. In regard to the former, the hospital in question uses a 5 by 8 inch card for its laboratory. This card contains a record of each examination made for the patient at any time and is used for making all reports. It is filed in the laboratory by an alphabetical system.

There are other methods, of course, which familiarity makes easy, but the card system furnishes a ready means of preparing monthly reports and of filing together all the laboratory work performed on any one patient. This question is one that can be met in each laboratory as the circumstances indicate.

A number of hospitals have visualized their laboratory work as being

of two types, routine and special. Routine examinations are all those made on the order of the minimum standards established by the hospital. If the minimum standard includes merely routine urinalysis, complete blood count, Wassermann and tissue examinations, then these examinations make up the report under the heading of "routine." If, however, more complete routines have been adopted, such as for pneumonia, these separate examinations, when initially performed because of the routine, are reported as routine. All other examinations obtained on order of the physician, even though some of those included in the routine are repeated, are classified as "special."

#### **Interpreting the Reports**

Our interpretations of the reports received might be something like this. A high percentage of routine examinations in a hospital where a complete routine procedure is established in some detail indicates a high quality of laboratory service. A high percentage of routine procedures in a hospital where only a partial routine is established indicates that there is little use made of the laboratory aside from ordinary routine procedures. These laboratory reports, in addition to classifying examinations as to routine and special, classify them according to types of patients, *i.e.* "hospital," "out-patient" and "public health." The hospital is particularly interested in observing the development of the laboratory service for out-patients and for the public health department as an indication of its value to local physicians and the community.

Let me reemphasize that the objective of every hospital should be the establishment of a laboratory service for the community. Through the method of fixed rates for in-patients and low rates for out-patients, the laboratory facilities are made freely available. Through methods of reporting examinations and the employment of a supervisor, its results are interpreted to the staff. Through the establishment of minimum diagnostic standards, the full use of the laboratory is stimulated and methods of study are devised. Only by such means can the type of laboratory service that is in keeping with the idea of the small hospital as a teaching hospital be assured.

# Nature Study as Mental Therapy

ARTHUR A. ALMON

Director of Conservation of Natural Beauty, Butler Hospital, Providence, R. I.

**B**UTLER HOSPITAL, for the treatment of mental and nervous diseases, offers its patients unlimited opportunities for close association with nature. It is situated on the east side of the city of Providence, R. I., and although it is within ten minutes' ride of the shopping district it comprises a tract of nearly 200 acres. It is located in the more pretentious residential section and is approached by a boulevard bordered by flowers and shrubs.

The grounds provide everything in the way of a sanctuary for bird and plant life: gentle sloping hill-sides, grassy meadows, a small pond, a brook running through a deep ravine, known as the Grotto, and a forest of many hard and soft wood trees that cover the bluff overlooking the Seekonk River. With a laboratory like this, what more could one ask? Walks and drives criss-cross the grounds and lead to all spots of interest; they also provide the patients and staff with many miles of pleasant and varied walks.

An interested friend of the hospital, realizing the value of such a wealth of natural material, has provided a fund for the purpose of giving instruction in nature study and the conservation of natural beauty. With such a fund and with a supervisor trained in nature study, a program is offered to the hospital patients and staff that acquaints them with some of the many secrets of nature throughout the hospital grounds. One of the favorite approaches in this study is the nature walk.

A typical nature walk starts with a group meeting and follows along one of the many trails. No one phase of nature study is especially stressed, but rather a general study of any and all interesting features observed along the path.

Because of the variety of trees, shrubs and flowers to be found at the hospital, part of the time on each walk is devoted to teaching simple methods of identifying plants in all

phases of their growth. During the spring and summer months the flowers vary from day to day and week to week and there are always new and different specimens for the patients to study.

One of the chief attractions for those who enjoy collecting flower

trees and shrubs—weeping hemlock, weeping spruce, sweet gum and Camperdown elm. To interest newcomers and visitors, many of the larger trees and shrubs nearer to the buildings are labeled with metal signs cut and painted by the patients at the shop. The patients are also encouraged in the observation of their surroundings by a number of colored slides of the flowers and gardens.



The thatched hut in which flowers, cones and pictures of birds were exhibited attracted hundreds of visitors during annual Open House Day.

specimens is the walk around our pond. Here in the spring are found Dutchman's-breeches, painted and nodding trillium, jack-in-the-pulpits, lady's-slippers and other native and cultivated plants. In the pond their attention is called to numerous goldfish among the pond lilies and to the trees reflected in the water.

In order to have flowers out of season, a plant press was made by a patient at the hobby shop and the members often bring in specimens collected on their walks to be pressed and preserved. These are mounted on cardboard and labeled with identification tags.

During the ninety-six years since the hospital was founded, friends have given many rare and unusual

During the winter months birds are fed at several places near the buildings. Feeding trays are placed outside the windows and after the holidays the Christmas trees are used to construct an attractive windbreak and shelter. The ground within this shelter is kept free from snow and birds feed there all winter long.

A list is kept of the birds seen on the grounds; during the first year of nature work a total of 63 species was recorded. On the list was Canada geese, a flock of 24 having spent a spring day in one of our coves on the river. The river remains open most of the winter and provides an excellent place for water fowl to rest and to feed while on migration.

A shelter with a straw-thatched





**Left:** A group of patients strolls along one of the many wooded trails in the hospital grounds. **Center:** The goldfish pond is a favorite haunt for walks and meditation. **Bottom:** One of the natural springs that is surrounded by a wealth of plant material.

roof was constructed from cedar slabs by a number of the nature enthusiasts. This shelter was used to house exhibits of pressed flowers, cones of conifers and pictures of the various birds found on the grounds. This exhibit proved popular and at the present time space has been made in the hobby shop where these and other exhibits will be on display. It is hoped that a nature museum can be established by the addition of



birds' nests, wasps' nests, various types of minerals and mounted birds and animals contributed by the patients, staff and interested friends.

Work of a constructive nature is also included in the program. In the early spring of last year the men set out hundreds of seedling red pines on the steep slopes of our Grotto. Before the hurricane of 1938, the Grotto had what is believed to be the only stand of large hemlocks within this state. During the storm thousands of trees in this area were lost, but it is hoped that by supplementing the pines and other seedlings with the remaining trees the Grotto will some day resume its former appearance of the forest primeval.

With the arrival of the Japanese beetles both men and women patients, as well as the nurses, work to

save the flower gardens from these pests. Forgetting their dislike for insects they hand-pick the beetles by the thousands from flowers and other plants surrounding the gardens.

Conserving and building up soil are also important to the program. Instead of burning leaves and weeds, all such material is saved to make compost and is thus returned to the soil.

Results have proved that nature study is accepted, enjoyed and absorbed by the patients. The walks conducted twice weekly have an average attendance of ten, and several times the attendance has been more than 20. On the few occasions



when it is necessary to cancel walks, many explanations have to be given.

The patients may be seen gathering hickory nuts and acorns for the squirrels. Many request the golden millet and sunflower seeds that have been purchased so that they may feed the birds. They collect specimens on outside trips and bring them in for identification. Inquiries are made concerning the identity and habits of birds, insects and animals.

One patient has her own collection of plant material which she has picked, pressed and mounted. Two others take pride in collecting specimens of trees and identifying them from handbooks. The patients have one garden and are planning and working on another. Here they not only pick the flowers, but dig in the soil and plant the garden and care for it.

The hospital library has a shelf of nature books available to those who are interested. These are supplemented by magazines and other literature on related subjects. The Audubon Society is cooperating in the project by lending exhibits, by donating literature and lectures and by posting notices of their activities. The state college has supplied some material and one of its professors gave an illustrated lecture with colored slides that was considered one of the highlights of the year's program.

There can be no doubt that this program is playing an important therapeutic rôle, for patients are spending hours outdoors in the fresh air and sunshine. The patient who has apparently completely withdrawn from his surrounding environment gradually finds a growing interest in the things about him as his health improves. He not only walks about the paths but uses his eyes to see and his ears to hear the things that nature has to offer. His thoughts are extended to new interests and away from his troubles to a world where animals, plants, insects and human beings play a part in an interlocking chain of events. No longer is a tree just an evergreen but a white pine, hemlock, spruce, fir or some other particular species.

With a new outlook on life the patient returns to his home where his interest in the study of natural history has now provided new uses for his leisure time.

## Moline Makes Itself Heard

MARGUERITE N. BROOKS

Superintendent, Moline Public Hospital, Moline, Ill.

THE little mistress of ceremonies of the Juvenile Theater, a popular half hour feature of WHBF, Rock Island, Ill., was a patient at Moline Public Hospital, Moline, Ill., recently. By moving the bed of the convalescent young mistress of ceremonies to the pediatric solarium, that room became the broadcasting studio and a program consisting of a wide variety—from hillbilly to classic and instrumental to dramatic numbers—was presented. The actors were a group of young professional radio players and radio musicians.

this way, while one crew was broadcasting from one location, the other crew would set up the sound equipment at the next point of program origin. The program, which might have been technically difficult, was easily arranged with the splendid cooperation of the WHBF radio staff.

The two announcers visited the various departments, described the activities vividly and interviewed patients, interns and department heads. The dialog was made natural and spontaneous by a previous visit



Moline Public Hospital's first venture into radio broadcasting revealed a new approach to hospital public relations in the community.

The appreciative audience consisted of the pediatric patients and their parents; patients throughout the house also had their radios tuned to WHBF and a receiving set was placed in the hospital lobby.

The response of the audience and the interest shown suggested a later tour of the hospital that was arranged the following week. The tour of an hour and fifteen minutes was broadcast by direct lines. To make the trip without interruption, it was necessary to have two complete amplifying units and two crews. In

to the hospital at which time the announcers acquainted themselves with the work of the various departments.

The tour concluded from the roof of the hospital where a beautiful view of the Mississippi River is obtained, giving the radio audience an impression of the scope of the hospital service and its place in the community.

Records were made of the entire radio tour and will be used in whole or in part for the future public relations activities.

# Clinics for Crippled Children

MILDRED RIESE, R.N.



Left: The front of the Orthopaedic Hospital out-patient department. The department houses a staff meeting room, an auditorium, a library and treatment rooms. At the rear of the building are the pools and 50 examining rooms. Below: The indoor-outdoor hydrogymnasium.



THE modern out-patient department of a hospital for crippled children bears little resemblance to the early dispensaries for the poor. Its objectives, therefore, should be clearly defined and well understood by the staff, the workers and the community. The out-patient department that is a vital part of the community health service and serves its patients well is never a sudden growth but is rather the result of well-balanced and gradual development. Sound clinic organization and patient management, together with adequate facilities, are recognized everywhere as essential.

The out-patient department of the Orthopaedic Hospital of Los Angeles was built ten years ago and planned specifically for children in need of orthopedic care. Not only medical care but early discovery of the potentialities of the child in the light of the type of adult he is likely to be are considered of primary importance.

Just what happens to the crippled child when he seeks medical attention at the institution?

As he and his parent enter the clinic they meet a volunteer who acts in the capacity of hostess. The registrar is expecting them, since all pa-

tients, except emergency cases, are given appointments. After the identification details are completed, a hostess introduces the patient and his mother to the admitting doctor.

A general examination is made to determine whether or not the patient is in need of the type of medical service rendered by the staff. If the patient does not require orthopedic treatment but some other type of medical care this is carefully explained by the doctor to the parent. Then the social service worker transfers him to another institution, makes an appointment for him and supplies a letter of introduction.

If the patient is eligible for treatment at the hospital, he is taken by a volunteer to an examining room, where he is prepared by the nurse so that the doctor may examine the body and gait.

The initial history is taken by the doctor or, under his direction, by the medical historian. During the examination the doctor is accompanied by a nurse and historian and an orderly is on call. After the orthopedist has examined the case, dictated his findings and recommendations for treatment, the hostess is notified to take the child and parent to the medical social worker for social ad-

mitting and interpretation of what is expected of them.

It is important that the medical social worker be sure that both patient and parent understand instructions and their own individual parts in the treatment process. Since the medical social worker is responsible for financial eligibility, she is given a fee schedule and is familiar with the "Budget Guide for Determining Eligibility to Voluntary Clinics."

A volunteer conducts the patient to medical and other clinics. As many clinics as possible are running simultaneously in order to reduce the patient's return visits, which, at best, are numerous over a possible period of years of treatment.

Friendly greetings from members of the hospital family and volunteers, colorful walls and furnishings, many books and provision for entertainment help to build up an informal and hospitable atmosphere.



# -A Community Service

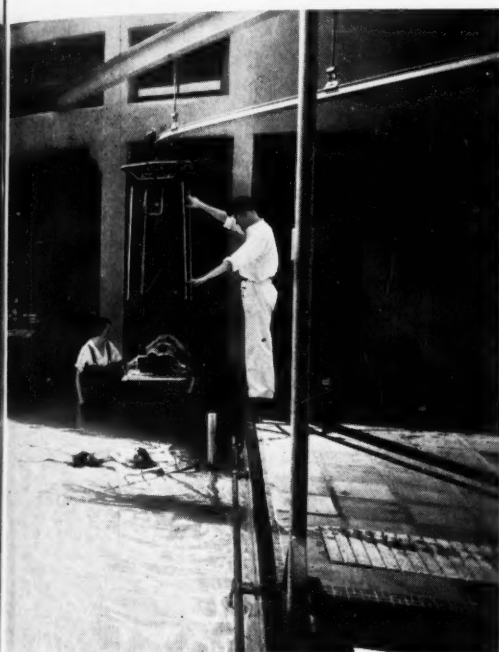
Superintendent, Orthopaedic Hospital, Los Angeles

While the hospital is devoted primarily to the treatment of orthopedic conditions, the patients receive complete out-patient care from a closed staff organization representing many fields of medicine. All the medical work of the institution is under the supervision of the chief of staff or

nurses are responsible for supervision of volunteers, aids and assistants. The visiting nurse has a similar background and calls on all discharged patients living within a

radius of 20 miles. Joint planning with the medical social worker solves many difficult problems.

As the majority of cases at the hospital enter through the out-patient department, the medical social workers are liaison officers between the



Right: A group of patients waiting in line for the Saturday morning movie. This is one of the forms of entertainment that are provided for the children. Below: The waiting room of the out-patient clinic. Adjacent to it are examining rooms, medical social workers' offices and plaster room.



some doctor to whom he has delegated special duties.

About 12 dentists give their services for orthodontia, extractions and fillings. Dental hygienists and a dental assistant are also valuable in the department, leaving the dentists free for their specialties.

The nursing personnel of the out-patient department consists of two orthopedic nurses, one medical nurse and a visiting nurse. All are registered nurses, who either hold certificates in public health work or have had five years' experience in out-patient departments.

They perform certain duties that are often overlooked in some hospitals, namely, interpreting the physician's instructions to patients and families; safeguarding the patients' records, and giving general health information to patients and families through group instruction, demonstration, posters and literature. The





community and the institution. At the present time, the responsibility for obtaining the initial social and financial data is shared by the director of medical social service, her assistant and the director of the clinic.

In gathering the admitting information, the social workers attempt to learn all family difficulties that may interfere with treatment and, also, to anticipate problems in convalescent care. The data obtained are recorded on cards that are filed in the director's office with the social case histories.

Only a few of the patients are given intensive social treatment, while a larger group receives single or short-time social services. The social workers also follow social problems referred by other hospital personnel and make medical follow-up calls requested by the doctors. A part-time secretary makes it possible to keep adequate social records.

The registrar or admitting clerk is a key person with many duties, including the collection of clinic fees. She is familiar with all of the clinics and, to some extent, knows where the patients are likely to be. She checks all cases for instructions on return visits and makes sure that patients have visited the clinics specified on their cards.

Six medical historians are available for taking the doctors' notes because permitting volunteers to record these notes would open the way for medical legal complications and violate

confidential data of the patients' records.

A roentgenologist is in charge of the x-ray department where technicians take and develop approximately 700 x-ray negatives per month. As the roentgenologist works on a part-time basis, his services are used primarily for reading the films.

The photographic department has three distinct functions: making records of the children; assembling movies and slides for teaching, and collecting pictures for the publicity department.

The physical therapists have degrees in physical education as a background for their highly technical tasks. These girls go into the pool with the new poliomyelitis, post-operative and fracture cases. As the temperature of the water is 94° F. the technicians are advised not to stay in the water for more than two hours consecutively. This work is alternated with duties in the gymnasium and physical therapy departments. Although physical therapy, occupational therapy and hydrotherapy are correlated, all have separate departments.

Many speech defects are diagnosed among the orthopedic patients, the most frequent being found in spastic paralysis and encephalitis cases. Difficulties range from absent speech through delayed speech, stuttering and lisping. The personnel of the department has a good background in the pathology of speech. The pro-

fessional workers' services are supplemented by selected and supervised speech students from the university, who carefully avoid creating tension and overstimulation.

The dietitian is actively connected with the public health program and her services are far-reaching. She not only checks on return cases in the out-patient department but also gives instructions to parents concerning special diets and preparation of foods, as well as information in regard to the brands of foods and cuts of meats. She performs a great service by informing the parents where and how to buy economically. The visiting nurse also assists the dietitian with some of the dietary problems in the home.

Administrative services, such as accounting, laundry and housekeeping, are provided through the departments that serve the in-patients. In fact, by having the hospital adjacent, the costs are decreased because all departments use the same administrative divisions. Many other services, such as the pools and physical therapy department, are available to both the in-patient and out-patient departments.

The purpose of the department of educational activities is to follow up the child's educational work, the beginning of which is correlated with the mental hygiene department and with educational work from the board of education. Later, this work is carried on by organized groups of former hospital patients, known as alumni, under the guidance of counselors.

Bimonthly meetings of various sections provide opportunity for educational and social outlets to meet the special interests of the different groups; for example, orchestra, dramatics, glee club, journalism, creative writing and practice of parliamentary law. A definite effort is made to sponsor programs that form the necessary bridge to outside activities.

Volunteers in the out-patient department—from the doctors who render professional services to the clinic mothers who come each week to mend—donate much valuable service. The corps of volunteers represents the foundation of community interest that is life-giving to voluntary hospitals. Its interest will bring dividends in sponsoring community relationships.



A patient gets a "work-out" in the physical therapy treatment room.

# Vacation and Sick Leave

## Allowances Made in 18 Hospitals

**L**INKED in the hospital regulations but as far apart as the two poles in the mental anticipation of the personnel are the topics selected for this month's little survey—vacations and sick leaves.

Let's consider the pleasanter topic first. On the whole, the 18 hospitals questioned are liberal with vacation leaves for professional and office personnel. Although the two weeks' vacation is standard, a number of hospitals grant nurses and other professional employees a full month and a few have established a three weeks' holiday period.

A sliding scale has been found a fair method of handling vacations. Most of the smaller institutions require one year's service before granting a two weeks' vacation.

Brady J. Dayton of Peninsula General Hospital, Salisbury, Md., reports a four weeks' annual vacation for nurses, after one year's employment. The same situation obtains at Webber Hospital, Biddeford, Me., Alice L. Bennett, the superintendent, states.

At Collis P. Huntington Memorial Hospital, Boston, according to the superintendent, Anna L. Gibson, nurses get two weeks' vacation if they have worked one year and four weeks if they have served the hospital for two or more years. The House of the Good Samaritan in the same city grants a three weeks' vacation to nurses and four weeks off for technicians, social service workers and other professional employees, after one year's service, according to Elma J. Hussey.

Three weeks is the regular holiday period at Owensboro-Daviess County Hospital, Owensboro, Ky., Frieda Dieterichs reports. Nurses, other professional employees and office employees are eligible after a single year's service.

Community Memorial Hospital, Ayer, Mass., allows one week's vacation for every six months' employment. This may be taken at the end of the six months' period, provided the employment is to continue, Dorcas Clark, the superintendent, asserts.

At Sunnyslope Sanatorium, Ottumwa, Iowa, the professional staff

and the office workers get two weeks' vacation after one year's service, three weeks after three years' service and four weeks after five years' service, according to Rose M. McClelland.

The superintendent, assistant superintendent, comptroller and nursing staff at Fitkin Memorial Hospital, Neptune, N. J., are allowed one month's vacation with pay after the completion of eleven months of continuous employment. The vacation period may not be split nor may double salary be received in lieu of vacation without the special consent of the executive committee, Anthony W. Eckert, superintendent, states.

As to other employees at Fitkin the vacation allowance is two weeks after fifty weeks of continuous employment. One half month's salary may be paid in lieu of two weeks' vacation on written approval of the superintendent.

Administrators were asked on the questionnaire sent them whether they consider vacations as a reward for past services or as a preparation for the work to come. Five of the reporting hospitals replied that they consider the vacation both as a reward and as a preparation. Another five regard it as a reward for past services. A third five regard the va-

cation as a preparation for future effort. Other hospitals questioned did not reply.

Some employers grant vacation time to persons leaving their employ. The 18 small hospitals in this study were asked to reveal their practices on this point. Eleven superintendents replied that the matter depends entirely upon the circumstances. Five make a policy of granting such vacations when they are due the departing employee. One is against the policy; one did not reply.

Many persons in the hospital field would like to continue their professional education through short courses, refresher courses or special studies. An increasing number of hospitals makes it possible for their nurses and other professional employees to rise in their chosen fields through advanced study without loss of job. Let us see what the policies of some of the smaller hospitals are in this regard.

Community Hospital, Beloit, Kan., will grant special leave of absence for further study, employing temporary workers during the period, Supt. Alma J. Stuive declares. Lutheran Hospital, Hampton, Iowa, makes the same concession, although it makes no effort to pay the salary of the per-

Table 1—Length of Vacations Granted Employees in 18 Small Hospitals

Personnel	Vacation Period				
	None	1 Week	2 Weeks	3 Weeks	4 Weeks
Nurses.....	..	..	12	3	6
Other professional employees.....	..	..	11	3	4
Office employees.....	..	1	13	4	2
Maids and domestic employees.....	3	3	12	..	..

Table 2—Amount of Sick Leave Granted Employees in 18 Small Hospitals

Personnel	Length of Leave						
	None	1 Week	10 Days	2 Weeks	3 Weeks	4 Weeks	Indefinite
Nurses.....	2	1	1	9	1	1	3
Other professional employees.....	2	1	1	8	1	..	5
Office employees.....	2	1	1	6	1	..	3
Maids and domestic employees.....	5	2	1	6	1	..	3



son absent on leave, according to Martha E. Hein.

Naeve Hospital, Albert Lea, Minn., retains the employe's position and gives him or her a salary advance upon return, Mary King points out.

Sue E. Borden declares that half-time pay allowance is made to employes at Mercy Hospital, Benton Harbor, Mich., who are absent on leave for further study.

One enthusiast for this type of leave is Katherine V. Shea of Emergency Hospital, Annapolis, Md., who was granted such a leave herself with full salary and part of her tuition paid.

Nothing has been said about vacations for maids and domestic help. Does current practice make a generous allowance to employes of this type?

A glance at table 1 will show that the majority of the hospitals questioned grant a full two weeks' vacation to maids and domestics. Only three hospitals make no provision

for vacations for housekeeping and kitchen help; three report a one week vacation, and 12 give two weeks, usually to those who have been on the pay roll for a full year.

Mercy Hospital, Benton Harbor, Mich., allows two weeks for the maintenance man and the cook but the other domestic help get one week only. Sunnyslope Sanatorium, Ottumwa, Iowa, grants one week's vacation to those who have worked a year, two weeks to those who have worked two years but never gives more than two weeks' vacation to workers of this class.

Now, as to sick leave, do we find hospitals pursuing the same fairly liberal policy evidenced in the vacation survey? The answer, it appears, is in the affirmative, as a study of table 2 will reveal. The majority of the hospitals grant two weeks' leave with pay.

Nurses get four weeks' sick leave with pay at Collis P. Huntington Memorial Hospital, and office em-

ployes are granted from one week to four weeks depending upon length of service.

No sick leave with pay is given maids and domestic employes in several of the 18 hospitals, namely, Illinois Central Hospital, Paducah, Ky.; Independence Sanitarium and Hospital, Independence, Mo.; Elizabeth Sullivan Memorial Hospital, Bogalusa, La.; Boone County Hospital, Columbia, Mo.; Community Memorial Hospital, Ayer, Mass.

Boone County Hospital, Columbia, Mo., while discontinuing the salary during an illness, makes no charge for hospitalization except for drugs, according to L. Eleanor Kelly, the superintendent.

Group hospitalization is changing the picture somewhat in the smaller hospitals. At Fitkin Memorial employes who subscribe to a hospital service plan receive full salary up to one week over and above the one week's or two weeks' regular sick leave with pay (one week for those employed more than six months; two weeks for those employed more than one year) and either private or semiprivate accommodations with no additional charge. The professional staff gets the private rooms and the office employes, technicians and other workers get the extra week's care in semiprivate accommodations. Any of the employes who do not subscribe to the plan receive ward care without salary during the period of hospitalization.

Graduates of the Fitkin Hospital's school of nursing who are in practice get private room care without extra charges if they are subscribers to the plan; if they are not subscribers they get such care at ward rates.

The questionnaire of the month asked whether an employe who has worked less than the period designed for full sick leave is eligible for a pro-rata share. Seven hospitals of the 18 reporting recognize this additional obligation. Celestine Pratt, superintendent of Biloxi Hospital, Biloxi, Miss., reports an allowance of one day per month's employment for either sick leave or vacation.

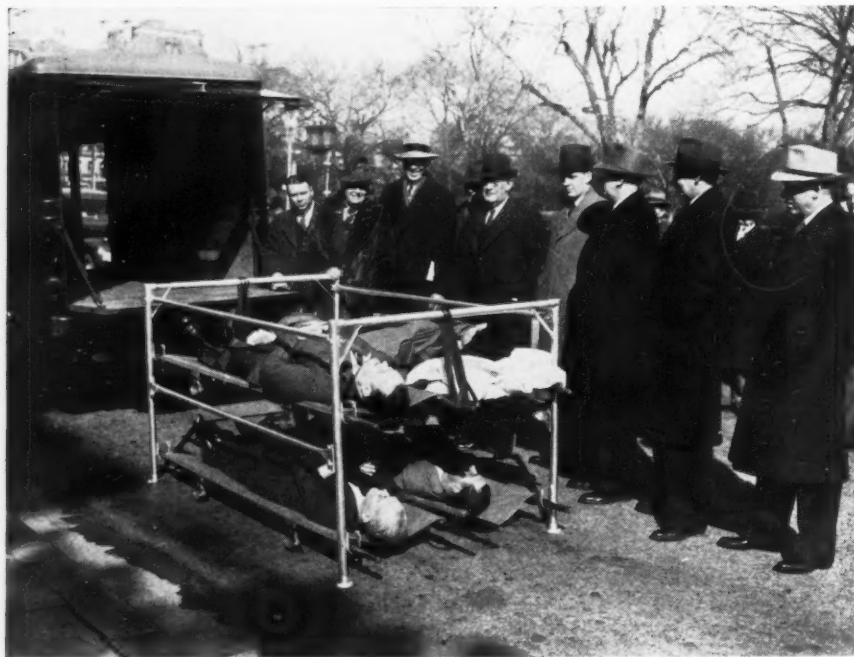
"If sick leave is not used during a particular year, do you think it should accumulate to the next year?" the hospitals were asked. To this question only one hospital answered in the affirmative.

## From Trucks to Ambulances

AMERICAN Red Cross and military officials recently witnessed a demonstration of a tubular iron stretcher carrier that is designed to convert an ordinary truck into an ambulance at a moment's notice. The frame is adjustable so that it can be made to fit into any size

truck. It was developed by Mabel T. Boardman, national secretary of the Red Cross, and costs about \$25.

Red Cross chapters throughout the country will be urged to obtain the stretcher carriers and train volunteer units to be known as "truck ambulance companies," to operate them.



Tubular iron stretcher carrier converts truck into ambulance.



# New York City Has a Plan—

## for Low Cost Ward Service

S. S. GOLDWATER, M.D.

President, Associated Hospital Service of New York

THE nonprofit hospital service plans constitute an increasingly important factor in the economic structure of hospitals and in the welfare of the people of our nation.

We have now reached a point where, I believe, the interest of the hospitals and of the public can best be served by expansion of prepaid, nonprofit services.

The Associated Hospital Service of New York is working on a project to extend its service to a new plane; namely, to the community or ward service level, by the development of a new low cost hospitalization service to be combined with a nonprofit medical expense plan that would provide for the payment of modest fees to participating physicians.

### Lack Means to Pay Doctors

The Associated Hospital Service finds that approximately 8 per cent of its subscribers, when the time comes for their admission to the hospital, do not have means to pay physicians' fees and request admission to public wards. This experience carries its lesson.

Some of these participants made a mistake when they originally subscribed for semiprivate service, which is beyond their means. Others, when they signed up, were in circumstances that warranted subscribing to the semiprivate plan, but when the moment arrived to face the crisis of hospital care they lacked the means to pay a medical fee and were obliged to fall back on ward care.

These subscribers, for the most part, belong to an economic group whose members, because of their modest resources, generally refrain from participation in the semiprivate plan; the group is made up of individuals whose incomes, reckoned on a family basis, do not exceed \$2000 per annum; their individual salaries are often much lower. When they do subscribe for semiprivate service, they are unable to go through with it.

During the last three or four months I have had conferences with

representatives of nearly a hundred of our leading group accounts, representing most of the big industries in the New York metropolitan area. Overwhelmingly, the personnel directors, spokesmen for the subscribers in these large concerns, tell me that there are large numbers of low income employees waiting for an opportunity to subscribe to a lower cost plan.

What would be practical in the way of a low cost plan? In order to be salable it must be within the means of the subscribers, and we are thinking now of individuals whose circumstances are such that a large proportion of them are eligible under New York City's rules and also under voluntary hospital rules for admission as free ward patients or as ward patients who are expected to pay only a fraction of the costs.

First, we must present a plan in terms within the means of those we wish to serve.

Second, if any wide extension of the prepayment principle is to be effected, it must be on terms that are advantageous and not prejudicial to the hospitals.

Third, it must be acceptable to the medical profession, without whose intelligent cooperation nothing can be done; and to make it acceptable to a majority of the physicians practicing in New York, prepayment of medical fees must be included in the plan.

Such medical fees, I have every reason to believe, would be generously calculated by New York doctors, who now serve most of the prospective subscribers to the proposed plan gratuitously. The attitude of the profession is shown by the fact that 16 eminent physicians (the number required by the rules of the state department of social welfare) have agreed to act as incorporators of a nonprofit medical expense indemnity corporation to be formed for the

express purpose of collaborating in this enterprise with the Associated Hospital Service. Included in this group are six presidents or former presidents of county medical societies. Moreover, a special committee of the coordinating council of the five county medical societies in New York City has approved the project in principle. Thus, the good will of medicine seems assured.

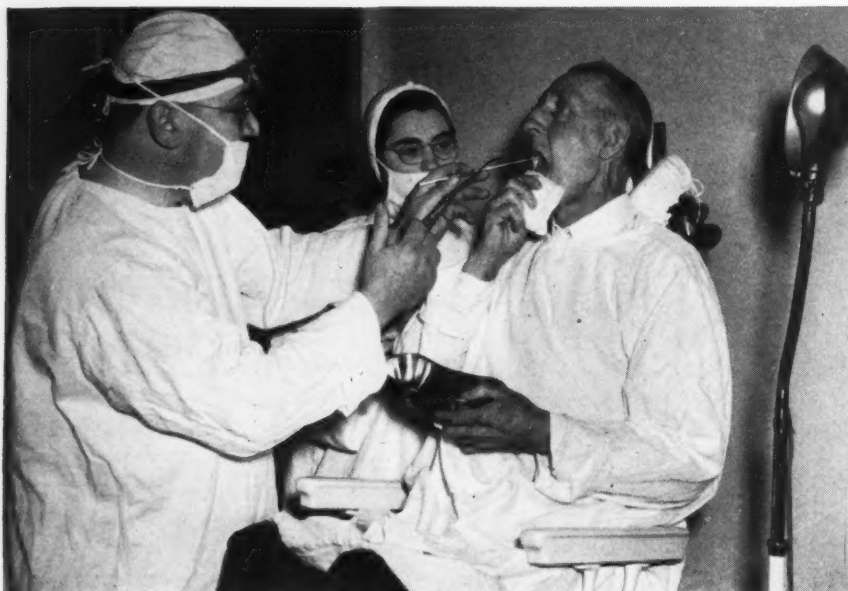
### Subscriptions for \$6 per Year

Let us consider the hospitals' interest in the matter. The personnel directors of large corporations, and some of our field representatives, believe that there is a reasonable chance of selling hospitalization subscriptions at \$6 a year to many workers who find the present plan of the Associated Hospital Service beyond their means. This should yield the hospitals approximately \$4 for each day of hospital care, and thoughtful superintendents will immediately reflect that this would mean \$4 charged and immediately paid, not \$4 entered doubtfully on the books.

Why should the hospitals bother with a contributory plan on a \$4 basis when the full cost of ward service in the better class of hospitals exceeds this sum? They should, it seems to me, for several reasons.

In the first place, the average income derived from ward patients today in the general hospitals associated with the United Hospital Fund is less than \$3 a day. In the second place, if by developing a ward service plan on a prepayment basis we can entirely change the attitude of a large number of persons of low incomes toward hospitals and toward hospital service, such a revolution will be brought about in the public relations of hospitals that hospital trustees will no longer have to sit up nights worrying about heavy deficits.

The plan, quite frankly, looks toward a new pattern of social cooper-



Photograph from Lancaster Memorial Hospital, Lancaster, Pa.

**Prepayment of medical fees is an important part of the proposed plan.**

ation, consisting of a partnership between a great army of industrial workers and the voluntary hospitals. The basic idea of this partnership is that the great mass of regularly employed workers will become regular contributors to a mutually helpful arrangement which protects the workers from medical indigency and which preserves for them an individual patient-physician relationship, while it assures to the hospitals a substantial part of the money that is needed to support the elaborate service and medical and nursing care that ward patients receive.

If we can get regularly employed people, under a system within their means, to organize and systematically to contribute to hospital care on a large scale as voluntary members of a system that will provide for their hospital needs in emergencies, I believe that we can put off indefinitely the threat of compulsory health insurance, with all its hazards, all its bewildering administrative complexities, all its bureaucratic defects and its inevitable excessive costs.

At the same time we can bring to an end the perplexing, the almost tragic, situation of voluntary hospitals that would like to continue their contribution to public health and welfare by a liberal policy of free care but find it impossible to obtain through philanthropic gifts the whole amount of the difference between present earned income and what satisfactory ward service costs. I have suggested that the individ-

ual subscriber's annual premium for ward service under the new community plan be fixed at \$6 because that would presumably be within the means of the people I have in mind and would yield a sufficient sum to improve substantially the position of hospitals that are carrying the heaviest ward loads. The family subscription rate might be two and a fourth or two and a half times the rate for an individual subscription. The premium would be definitely determined on the basis of a careful analysis of the experience of the Associated Hospital Service in dealing with its 1,250,000 present subscribers. The medical expense premium would be a separate and additional charge similarly calculated.

Some hospital administrators may think, "Well, if you have an insurance scheme, why shouldn't the payment to the hospitals cover the whole of the cost?"

That would be an entirely reasonable proposal to make if we were dealing with business concerns—not philanthropic institutions—and with subscribers of sufficient means to foot the bill. Actually, we are proposing a plan suitable for philanthropic institutions that have been given and wish to retain certain rights of tax exemption and the privilege of appealing to the public for support both directly and through such agencies as the United Hospital Fund and the Greater New York Fund. Furthermore, the plan is designed to benefit relatively poor people.

In some instances, hospitals that would logically fit into the scheme have over long periods already received voluntary donations totaling millions of dollars intended for medical relief. Surely, these hospitals not only wish to continue but have an obligation to continue the voluntary service which has been entrusted to them and for which, in fact, the founders originally created and endowed them.

If a plan were set up that would cover on a strictly business basis the whole cost of caring for all of the charitable work now being done in the wards, it is obvious that the whole moral fabric and social significance of the voluntary system would be undermined, that the voluntary hospital would cease to be a charitable institution, that it would become a business enterprise pure and simple and that social reformers who are eager now to abolish many of the privileges and exemptions of charitable institutions would be supplied with fresh ammunition for a renewal of their hostile attack.

In what way and to what extent would the proposed plan affect the existing fiscal relations between the municipality and the voluntary hospital? What will actually happen I cannot say, but I have a perfectly clear idea about the kind of adjustment that ought to be made.

If the community or ward service plan is successful in any large measure, a substantial part of the money that New York City is now giving toward the support of ward cases in voluntary hospitals will be released. If the whole sum now thus contributed—a sum amounting to several million dollars—is no longer needed for the support of ward patients now classified as medical indigents (under the proposed plan these patients would be largely cared for by the prepayment method), it would be reasonable to ask the city authorities to shift all or a substantial part of this sum toward the support of free out-patient services for which nothing is given today.

The city could well afford to shift its support in this way. Free out-patient service for the indigent is a service in which the municipality is vitally interested, and about two thirds of it in Greater New York is now being rendered by voluntary hospitals without public assistance.



# The Tropics Transplanted

## to Edgewater Hospital's Solarium

M. L. BUSCH, M.D.

Superintendent, Edgewater Hospital, Chicago

THE solarium that occupies the top floor of Edgewater Hospital, Chicago, helps to transform the pale, peaked convalescent into a robust individual who leaves the hospital with a Florida tan.

Originally, the solarium was planned as a complete physical therapy unit, particularly for the treatment of arthritic patients, and included mineral baths, massage tables and electric cabinets, as well as short-wave, ultraviolet and diathermy equipment.

However, because of its delightful atmosphere, the solarium soon became a definite part of the hospital routine for convalescent care. At present it is frequented by out-patient arthritic patients, by products of the nerve-racking business world who are in need of relaxation and by house patients who are hospitalized for long periods of time with chronic debilitating diseases.

The solarium consists of a glass enclosed section and another part open to the sky, which is used during the summer only.

A large room is covered by glass that has been especially treated to permit penetration by the sun's rays. In midwinter on sunny days, the temperature in this room often rises above 100° F. without the aid of artificial heat and the humidity varies from 20 to 30 per cent.

This room is gaily decorated with chaise longues, deck chairs and stationary swings. Large native Florida palm trees are placed in the corners and leafy plants are suspended from the ceiling. Three of the overhead lights are equipped with low voltage ultraviolet lamps, under which patients may safely sit for hours without fear of skin burns.

A built-in mosaic fountain occupies part of one wall; it furnishes tap water, cooled Waukesha spring water and bottled mineral water from separate spouts. A few modernistic tables, a radio, and cages housing singing canaries complete the furnishings of this colorful room, the appearance of which is further enhanced by a red tile floor.

Leading from the main lounge are hydrotherapy units for men and for women. These two rooms are identically equipped with large tubs in which mineral baths and whirlpool treatments are given. There are also a comfortable air-cushioned massage table and an enclosed lavatory. The men's and women's treatment rooms are separated by a small room that contains an electric cabinet which liberates intense heat for the treatment of conditions requiring high thermal reactions.

Opposite these rooms are two sun rooms enclosed by glass bricks. In these rooms, in addition to a treatment table, are ultraviolet lamps, diathermy machines and reducing devices. Movable shutters afford the patient the direct rays of the sun in strict privacy.

Another small room opening off the main foyer is equipped with an examining table, blood pressure ap-

paratus and a cabinet containing the equipment necessary for the examination of patients prior to physical therapy.

The roofless outer division also is beautifully appointed. The low wall protecting the outer roof is lined by boxes of geraniums, petunias and roses.

Here, too, are modernistic chairs, swings and divans. On one side a striped canopy extends over a glass topped table and four matched chairs. On another side is a movable cabinet large enough to hold a person in the prone position and made of a peculiar type of sea shell that permits the penetration of the sun's rays. From this outer roof, one gets a bird's-eye view of Lake Michigan.

The personnel of the solarium consists of an examining physician, a masseuse and a masseur and attendants whose task it is to keep the solarium always clean and inviting.

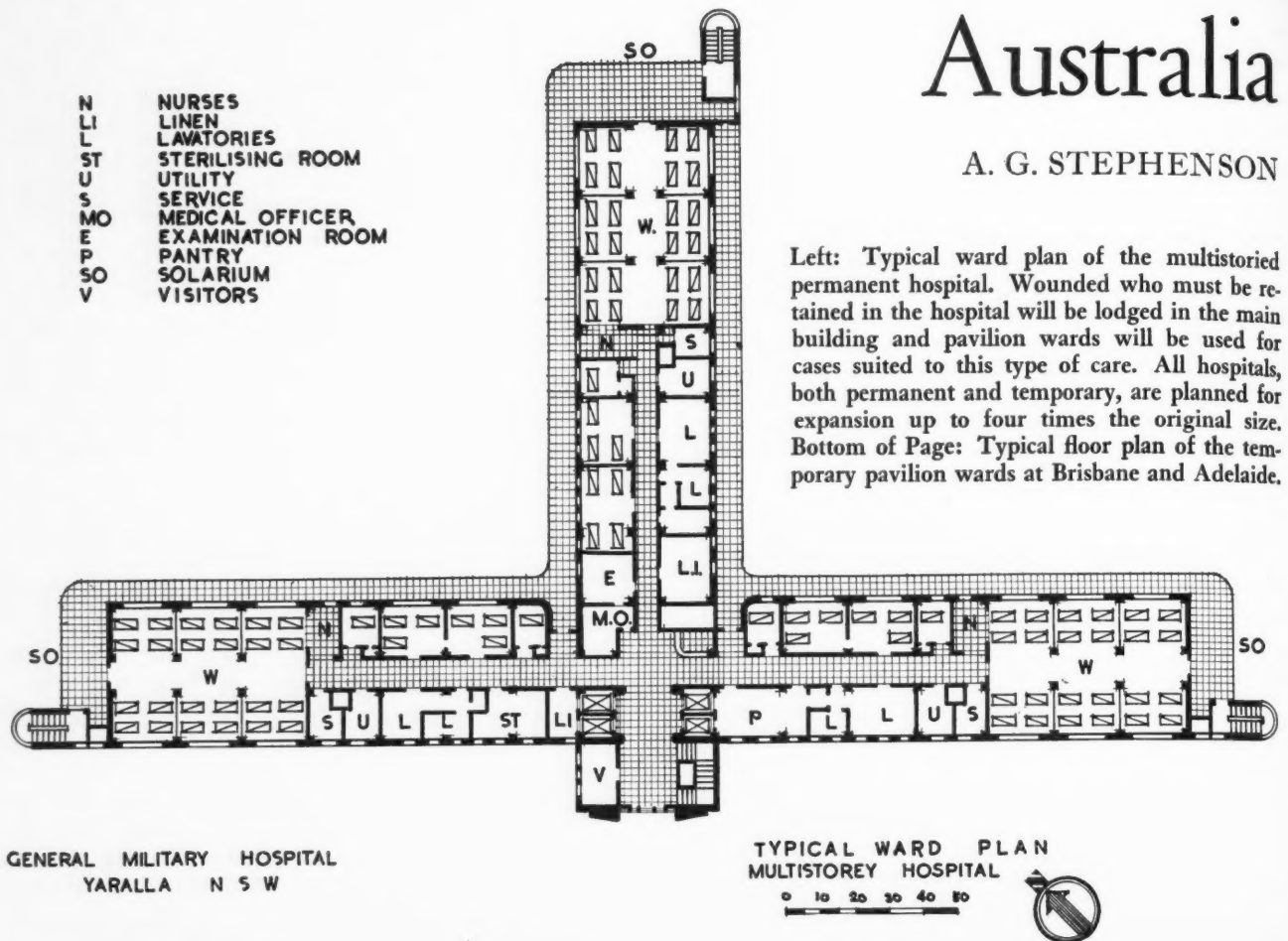


The colorful solarium atop Edgewater Hospital, Chicago, is complete with canaries, palm trees and sun lamps, all calculated to speed convalescence.



# Australia

A. G. STEPHENSON



THE last war found Australia without any suitable military hospitals and, as a consequence, buildings of a temporary nature were rushed up in various centers to take care of the thousands of wounded that were returned. Most of these temporary buildings have been in use as hospitals ever since. They have been added to and altered but never replaced.

The minister for the interior, Senator Foll, and Mr. Spender, the minister for the army, were primarily re-

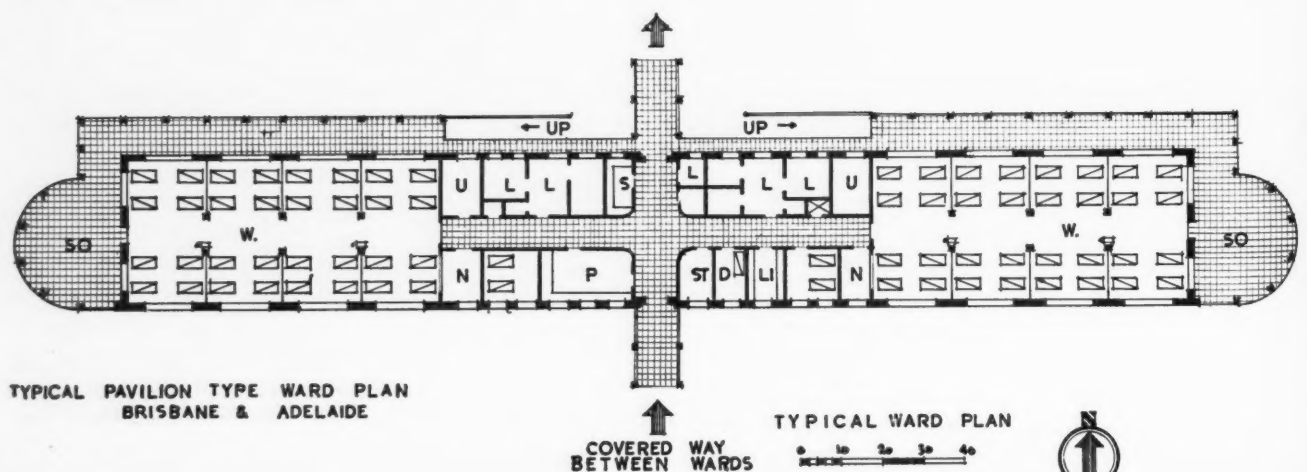
sponsible for formulating the scheme for the new military hospitals on sound and established principles.

They are divided into the following categories: (1) camp hospitals to take care of sickness during training; (2) temporary pavilion types; (3) permanent pavilion types, and (4) permanent multistorey hospitals in the two main centers, Sydney and Melbourne.

The military authorities prefer hospitals of the pavilion type primarily because they take less time to

build; they are generally less costly; building materials can be used in their erection that are not urgently required for military purposes, and they can be most readily extended.

It is axiomatic that for the greatest economy the site of a pavilion type of hospital should be practically level or else should be selected with a grade not exceeding 1 in 18 or 20. Such is the case with the hospital at Adelaide, where the site is ideal for both aspect and grade. On the other hand, where a site may be ideal from



# Prepares for the Wounded

Stephenson and Turner, Architects, Melbourne and Sydney, Australia

the point of view of accessibility and other reasons, but does not have the proper grade, it follows that we must build multistoried service buildings with a three or four storied central corridor, provided that the pavilion type of wards are to be used. Such is the case of the General Military Hospital in Brisbane.

Naturally, each site has its problem, but the basic requirement of each of these pavilion type of military hospitals is that it must be planned for expansion up to four times its first development. For instance, at Brisbane the scheme is prepared for expansion to 800 beds. We are now building wards to accommodate 200 wounded men and have arranged all services, stores, kitchens, operating rooms and boiler capacity to care for 400 patients with the plans drawn so

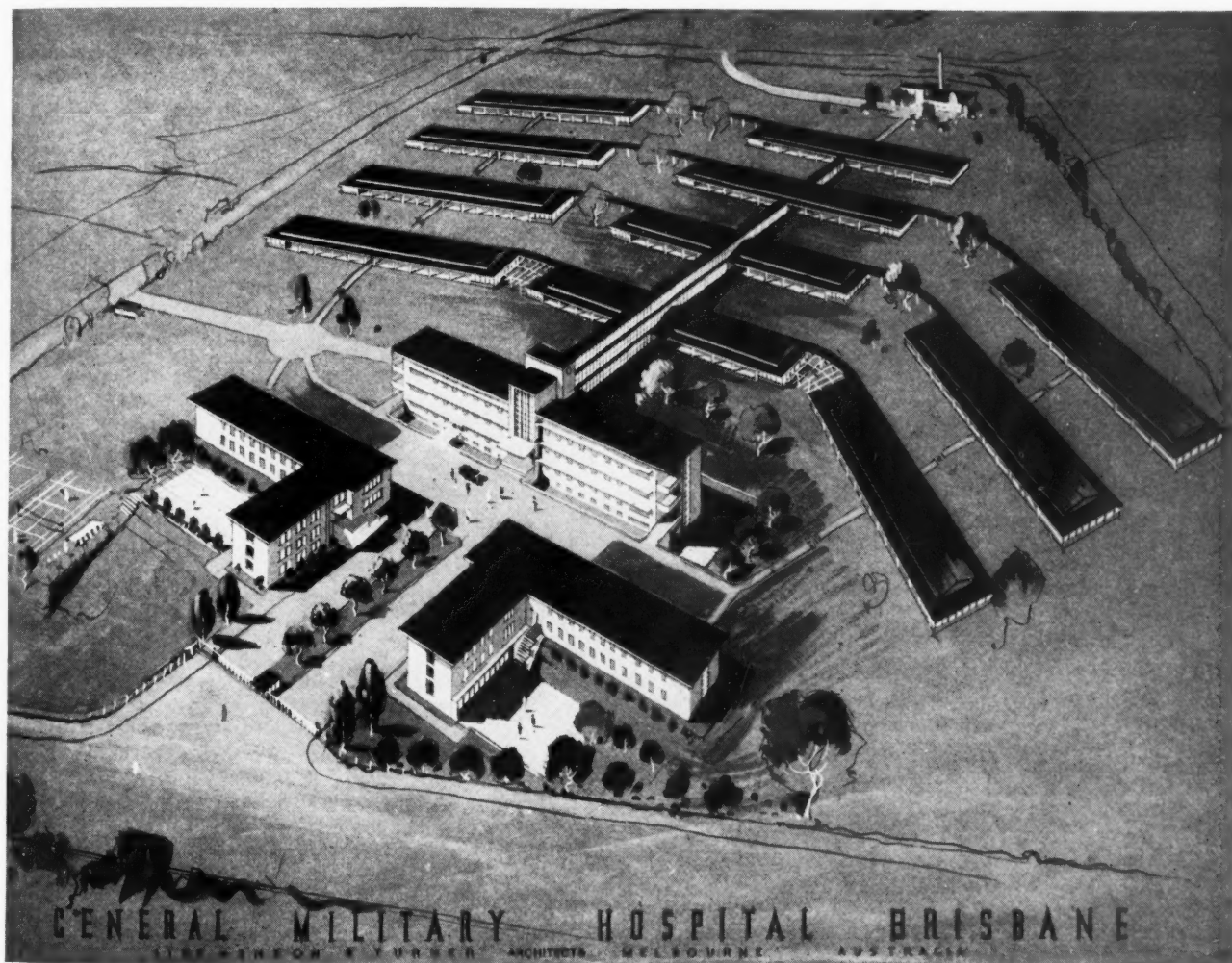
that in each department additions can be made as the bed capacity increases beyond that figure.

Two permanent hospitals are being built. The larger of these, situated near Sydney, is planned to house 600 beds. It is on an ideal site between two arms of a river. It is intended that the wounded who must be permanently retained in the hospital will be housed in these buildings where maintenance and running costs will be reduced to a minimum. The permanent pavilion wards will be used for cases that are especially suited to this type and the temporary pavilion hospitals will be demolished, we hope, when the war is over and the wounded are discharged.

Each hospital is provided with an examination and treatment clinic and a physical therapy department that



Above: A map showing the locations of the military hospitals. The key is as follows: "A"—Adelaide, South Australia; "M"—Melbourne, Victoria; "Y"—Yaralla, New South Wales, and "B"—Brisbane, Queensland. Below: Architects' drawing of the hospital at Brisbane, which is planned for expansion to 800 beds.





will grow as occasion demands. Provision is also being made for re-education of patients' limbs, the fitting of splints and false limbs and the care of ailments contracted on military service. These hospitals are not planned to cover the scope of the veterans' hospitals in the United States but are to care for wounds and ailments contracted by soldiers on active service.

The staffing of these hospitals may be of interest. The superintendent or commanding officer is a senior officer of the army medical corps. There are, of course, a number of other medical officers on the staff. On the business side, the quartermaster takes charge and draws all supplies, *i.e.* medicines, clothing and provisions, from the central military stores. On the nursing side the duties are carried out by army sisters, voluntary aid detachments and army medical corps details, such as orderlies, dressers and batmen.

For the 600 bed multistoried permanent hospital, plus 240 beds in the permanent pavilion section, the proportions of staff to patients are—royal medical officers, 14; army sisters, 100; voluntary aid detachments, 56, and army medical corps details, 112. These proportions are general throughout all our military hospitals. For the permanent hospitals the

military authorities wisely required that the minimum area to be allowed per ward bed was 100 square feet. This area is to be clear of all obstructions. For the pavilion type, 80 square feet per bed is permitted in large wards. Each permanent ward unit contains one large ward of 24 beds divided by glazed screens into six units of four beds each, plus two wards of three beds each and two single bed wards, making a total of 32 beds per ward unit.

All beds are arranged parallel to the outside walls in pairs so that the freest possible circulation of air is obtained. The windows of all wards occupy two thirds of the wall surface and can be opened to the floor. By this means beds can be moved out onto the veranda.

In the pavilions 32 beds are similarly arranged in the large wards with a two bed ward in addition. Therefore, there are 68 beds in two units for each ward pavilion, with one pantry and one sterilizing room serving the whole unit.

It is estimated that a third of the patients in all military hospitals will be ambulatory in one form or another; hence, ample provision is made in each ward for smoking rooms with lavatories adjoining them. These have been provided in the form of large enclosed solariums.

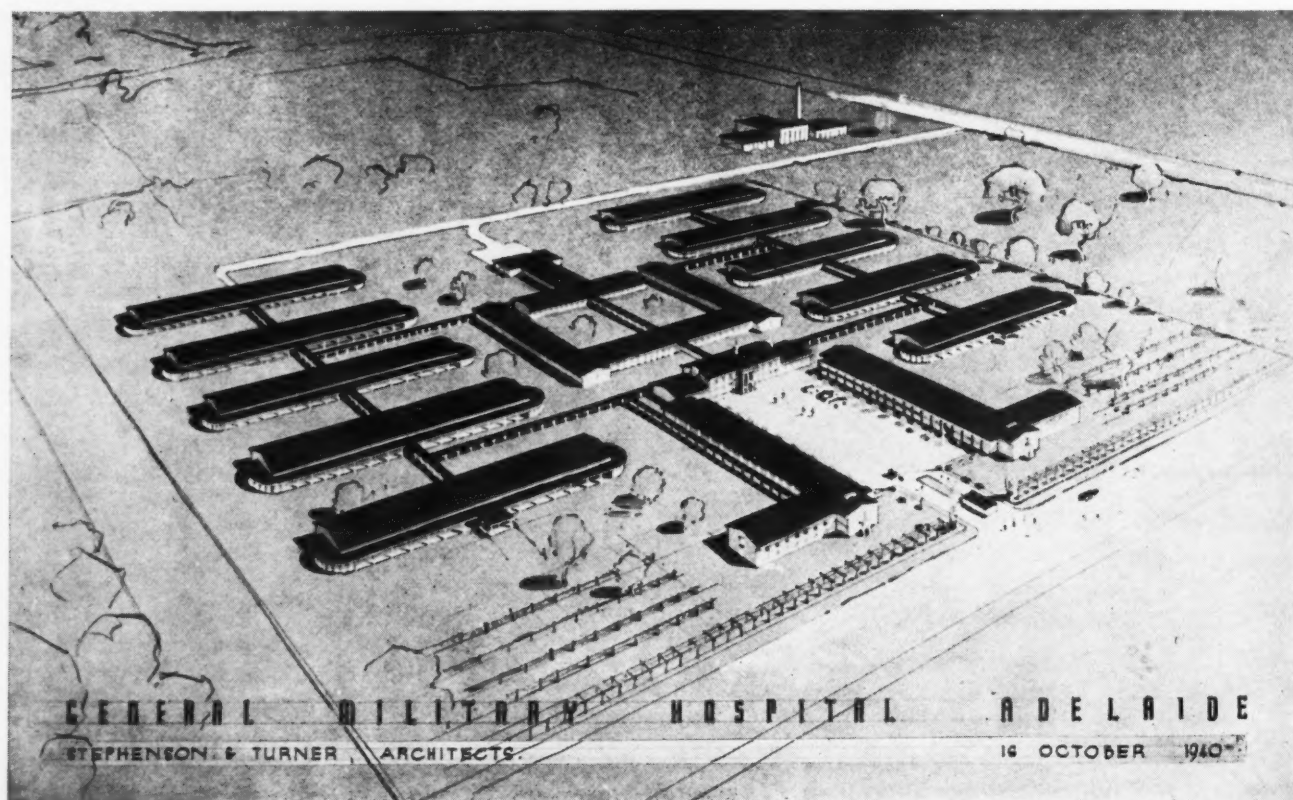
Extra accommodation is also provided in the dining rooms for ambulatory and convalescent men.

No special provision is being made for officers, except that one or more wards will be allocated for their use as occasion demands and, in special cases, a standard enclosed unit will be provided where high ranking officers may have private accommodations.

We adopted the three ward unit plan in the permanent hospital as the most economical of construction, supervision and maintenance. The plan of 600 beds suits such a unit admirably. In this plan an endeavor has been made to centralize all services insofar as possible and thus save in equipment and distribution.

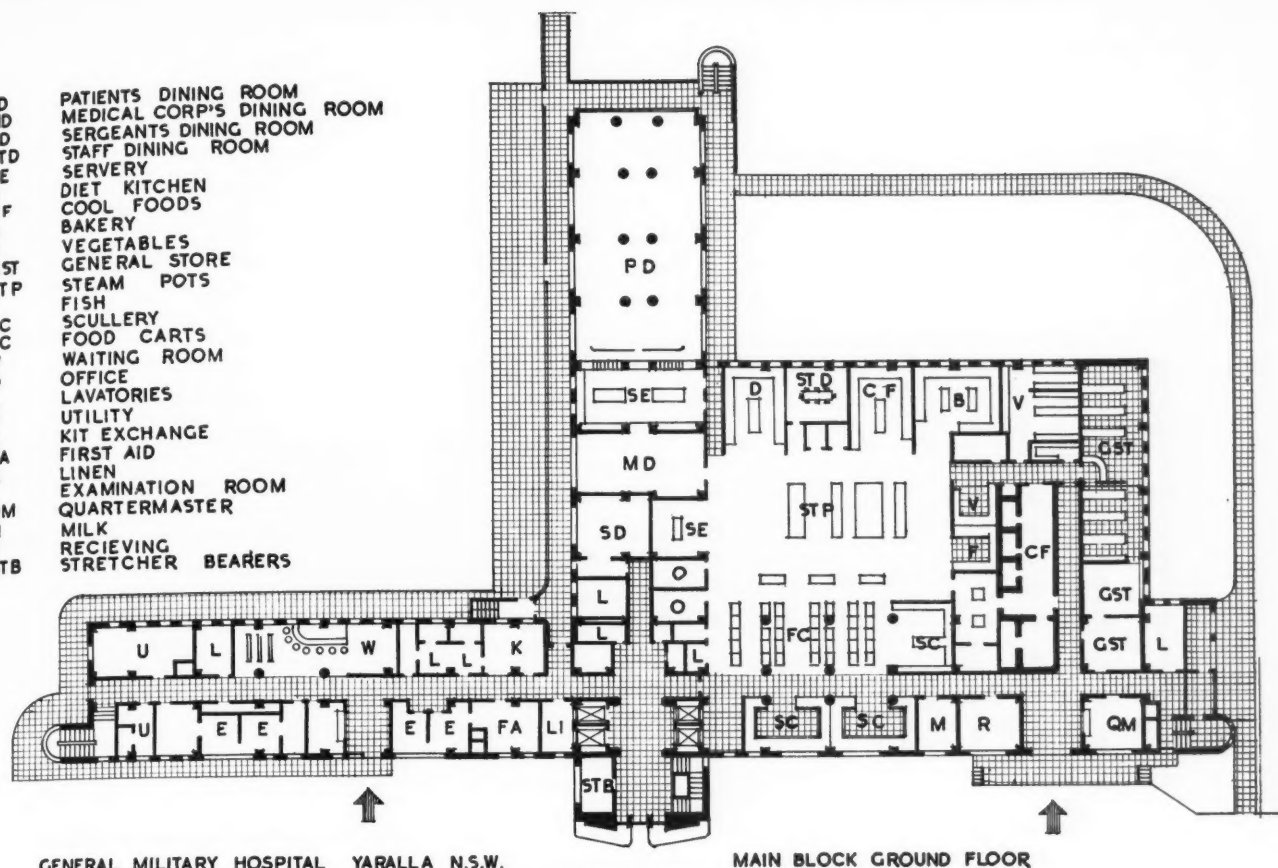
The reception of patients is an interesting problem because they will arrive en masse, either by hospital ship or train, and must be classified and distributed as quickly as possible to the various ward units. Hence, special ambulance facilities are provided, as well as examining rooms, a clothes issue center and, most important, a canteen where hot drinks can be distributed.

The lifts are directly accessible from this center and discharge the patients at the various ward floor levels or to the operating unit, as may be required. The minimizing



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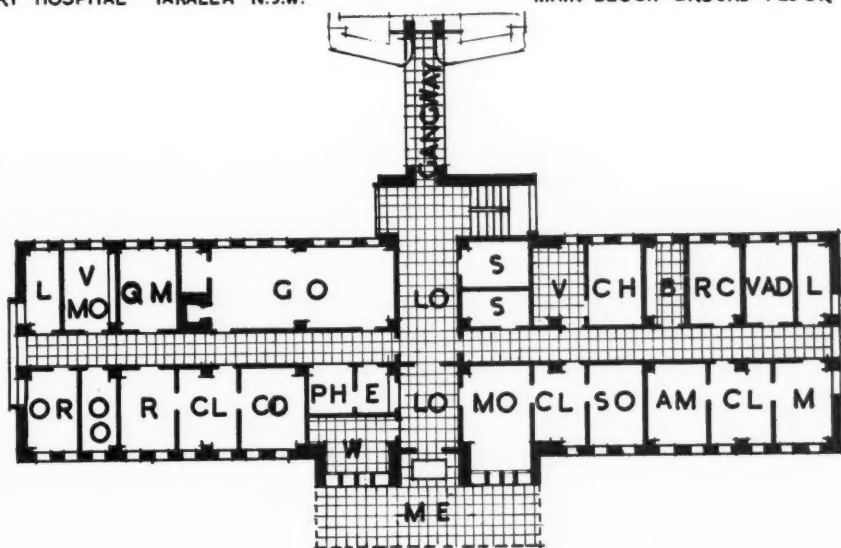
PATIENTS DINING ROOM  
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SERGEANTS DINING ROOM  
STAFF DINING ROOM  
SERVERY  
DIET KITCHEN  
COOL FOODS  
BAKERY  
VEGETABLES  
GENERAL STORE  
STEAM POTS  
FISH  
SCULLERY  
FOOD CARTS  
WAITING ROOM  
OFFICE  
LAVATORIES  
UTILITY  
KIT EXCHANGE  
FIRST AID  
LINEN  
EXAMINATION ROOM  
QUARTERMASTER  
MILK  
RECIEVING  
STRETCHER BEARERS



GENERAL MILITARY HOSPITAL YARALLA N.S.W.

MAIN BLOCK GROUND FLOOR

Opposite Page:  
Drawing of the  
Adelaide Hospital.  
The site of this  
hospital is ideal in  
both aspect and  
grade for the pa-  
vilion ward type of  
construction. The  
temporary hospi-  
tals will be de-  
molished when  
the war is over.



Above: The  
ground floor of  
the main block of  
Yaralla Hospital.  
Provision is made  
for examination  
and treatment  
clinics and a phys-  
ical therapy de-  
partment. At Left:  
Administration  
block of the  
Yaralla Hospital.

of transport is as important in a military hospital as in any other so the transport lines in this permanent hospital have been carefully studied.

There are a number of ways whereby service traffic for pavilion hospitals can be arranged, but it has been proved here that direct access through the center of the ward unit is the most economical, both of distance and of cost.

There are objections, however, in that if doors are put across this corridor they must constantly be opened for traffic. The alternative is to leave the ward units open to possible entry

by unauthorized persons. Of course, in the multistoried hospital, this problem is nonexistent.

The permanent hospital comprises 600 beds, a small out-patient department, an operating suite of three theaters, a dental clinic, a physical therapy department, an x-ray department, laboratories, accommodations for 282 employes and a boiler house and laundry equipped to service 1800 beds.

The cost of this hospital, including fees and all equipment, except for movable furniture, was £680,000, or \$2,040,000. On the basis of 600 beds,

this is \$3400 per bed. The pavilion type of hospital at Brisbane, including 224 beds, administration quarters, accommodations for the staff and a boiler house and laundry, cost £235,000, or \$705,000. This comes to \$3150 per bed for 224 beds and, of course, takes into consideration the multistoried service buildings and the superimposed central corridor.

The 175 bed Adelaide Hospital, now under construction, will cost £150,000, or \$450,000. If one of the pavilion ward units is added to either scheme, it will cost £12,000 for a unit of 68 beds, or \$530 per bed.



# Essentials of Food Service

## From the Administrative Angle

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FROM the standpoint of the patient the standard of food service maintained in a hospital is of prime importance. Generally speaking, it concerns him even more than professional treatment. Consciously or not, it is the criterion by which he judges the administrative efficiency of the organization and upon which its general reputation stands. Therefore, and also because food service represents an appreciable slice of the budgetary pie, it should be of more than passing interest to the administrator. That this fact is overlooked in many otherwise well-conducted establishments is unfortunate.

### Factors Governing Efficiency

An efficient food service is dependent upon a number of related essentials. These include adequate facilities and equipment, competent personnel and intelligent organization, plus painstaking supervision. Variations in certain features are necessary, according to the needs of the particular hospital; for instance, in the type and layout of the buildings, the number of patients and whether or not they are ambulatory, bed cases or both.

Facilities and equipment are of first importance and should be given careful thought. Storage spaces, including refrigerators, should be of ample size and located conveniently for the receipt and issue of provisions. Efficient, dependable mechanical refrigeration is, of course, preferable but in no instance should a single compressor unit be relied upon.

Storage and disposal of garbage should also be considered. A conveniently located wet-garbage incinerator is a satisfactory but rather expensive method of disposal. A refrigerated garbage compartment is the next best answer and, if the garbage is sold, is comparatively inexpensive in the end result.

The kitchen or kitchens should be well designed and adequately equipped. If it is practicable, it is

The opinions or assertions contained in the article are those of the author and are not to be construed as official or reflecting the views of the Navy Department or of the Naval Service at large.

more economical to prepare all food in one kitchen. This arrangement facilitates more careful supervision. Opinions differ somewhat on kitchen equipment, although it is now more or less standardized as to type.

Certainly, there is no question of the superiority of a cafeteria system for serving the staff and ambulatory patients. It should, however, be designed for serving a wider variety of foods than is provided for in most such installations. A sufficient number of spare steam table inserts permit preheating and, in many instances, actual cooking of food in the same unit that goes to the serving counter. A grill section provides for direct and much more satisfactory serving of all fried foods. Hot and cold drink urns, a crushed ice dispenser, trays that are light and easy to clean and other odds and ends complete the cafeteria serving picture.

In an institutional dining room the most important features are the type of flooring and the design of the tables. The flooring should be durable and easily cleaned. Quarry tile is highly recommended. As for tables, a recent interesting design features swinging bracket seats. Such tables are equipped with a stainless metal or chromium or cadmium plated frame and with a durable, attractive, sanitary composition top in a choice of colors.

The serving system for bed patients should be adapted to the establishment. In a multi-storied building, where tray service is used, the most effective method utilizes automatic conveyor-hoist equipment. The tray bearing a name card, which may be of different color to indicate the type of diet, is placed on the conveyor, is quickly loaded, passes the dietitian for inspection and is then automatically whisked up to the proper floor to be served, all within about three minutes.

In many establishments the diet cart, of either the bulk or the tray

type, is the only practical method for room service. Either type of cart should be electrically heated and provided with a cold compartment if only one style of cart is used. Use of the bulk type of cart is recommended wherever practicable for it brings the dietary personnel into direct contact with the patient, permitting him to make a selection of food that can be appetizingly served in the quantity desired, thus reducing waste. The one and only objection is that the trays are set up and served at the bedside.

### Selecting the Personnel

The personnel, from the dietary supervisor on down, may make or break the reputation of an establishment and may even make or break it financially, as well. It is impossible to conduct an efficient food service with low paid, incompetent personnel. In no other department will well paid, superior employees be so conspicuously a bargain. Not only do they contribute to a highly satisfactory food service but may more than save the difference in their wages in doing it.

Naturally, the most important individual to be considered is the supervising dietitian, who should be carefully selected and given the entire responsibility of the department and all correlated details. Cooks should also be carefully chosen and be well enough paid to make the position attractive. A superior institutional cook is necessarily a conscientious craftsman of long training; yet, it seems, they are traditionally under-compensated in comparison to other crafts.

Procurement of provisions rarely offers difficulties. In practically all governmental, and some nongovernmental, establishments, provisions are obtained under competitive contract. Competition among reliable dealers is desirable but the common fault of the contract system, especially in governmental activities, is that the term



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of the contracts projects unreasonably into the future. As a result the dealer must bid sufficiently high to protect his interests in the event of unpredictable fluctuations or stand to lose.

### When to Prepare Food

Preparation of food is next in order. It is here, as well as in serving, that superior employees pay dividends in both savings and satisfaction. It seems common to the institutional cooking fraternity, for example, to prepare food far in advance of the meal hour, with the result that it is less edible and much of it is discarded. Cooking should be completed only a short time before the food is to be served.

Serving is as important as proper preparation. With a cafeteria system for ambulant and the bulk type of carts for nonambulant patients, an unusually wide variety of foods can be served without increase in cost, provided edible waste is effectively restricted. This rather novel idea has been proved a truism by years of experience in a certain few institutions.

Three factors enter into a per diem food cost: the cost of provisions, the type and standard of food service maintained and control of avoidable waste, the last two of which are governable.

Through concentration upon the two governable factors, this policy of food service may be pursued in any institution. Waste is controlled in both the preparation and serving, as well as at the garbage can end of the food serving sequence. To initiate this system successfully it is first necessary to "sell" the policy to the dietary employees and to all individuals served. The second step is gradually to offer an increasing variety of well-prepared food, permitting ambulant patients to help themselves and bed patients to indicate the choice and amount of food desired.

A rigid restriction must be enforced on the few who have a tendency to overestimate their capacity. Wasteful individuals may be appealed to by informing them that a real effort is being made to establish and maintain the most satisfactory food service that an arbitrary cost level will permit and that the quality is, therefore, dependent upon their

cooperation in avoiding waste. The policy of furnishing a wide variety of all the good food patients wish to eat, but none to throw away, will be immediately and enthusiastically accepted. Within a short time edible waste will fall practically to zero.

This policy and system of serving can be adopted with highly satisfactory results by any well-managed establishment at no increase over its present food cost. For that matter, it can be established at any reasonable predetermined cost but, of course, the standard will be commensurate with the cost.

In addition to the rigid restriction on waste, the factors that cause the "large-variety-choose-for-yourself" system to succeed without increase in cost are extremely simple.

First, the average individual will consume only a certain amount of food regardless of the quantity, quality, variety or the frequency with which it is offered. The gross poundage will vary somewhat, depending upon the types of food and the standard of food service, but it will approximate 7 pounds per diem.

Second, although certain limitations must be placed on the quantity of high cost items in order to keep within a certain predetermined standard, a variety and choice are offered and no restriction is placed upon the average and low cost items to which the individual resorts to satisfy his appetite. The cost is held constant merely by manipulating the use of the more costly items.

### Cost of Waste Food

Let us consider specific examples of the waste factor. In a certain institution in which the current food cost approximates 60 cents per diem, it was apparent upon investigation that the cost of the food consumed was actually but 40 cents and that the remaining 20 cents was being spent only to fill garbage cans. Edible food waste in this institution averaged 2.4 pounds a day per individual. This seems incredible but is not so uncommon as might be supposed. A well-managed food service of the type described above in another institution consistently holds the edible waste factor at approximately 2 ounces a day. This approaches an irreducible minimum.

Assume that 200 individuals are served at a per diem cost of 56 cents,

consuming 7 gross pounds each, including milk, at an average of 8 cents per pound. The net poundage served, properly seasoned and with most of the inedible "tare" eliminated, costs approximately 12 cents per pound. Suppose a garbage can of 200 pound capacity is half filled every day with edible waste. The actual cost of that half can of garbage is \$12 or 6 cents per individual served. All dietitians are aware of the difference in food service that an additional 6 cents will provide.

Most governmental and some of the large nongovernmental institutions are required to operate on a budgetary basis, including provision costs. It would be a forward step to predetermine an average standard of food service for the several hospitals under their jurisdiction, in light of available funds, and allocate the funds according to local differentials in provision costs. Why should one hospital, where costs are higher, be required to maintain a materially lower standard than another that has an advantage in prices?

### Allocating Food Funds

It is quite possible and feasible to formulate and adopt a workable yardstick as a guide in allocating available funds. By first selecting a typical hospital and assigning a dietary expert of known competence to take charge of its food service, an acceptable standard can be formulated, according to available funds, to be adopted by all other hospitals in the group on a basis of comparative costs.

With this method, the indicated cost for each hospital would be arrived at by computing the provisions used in the typical hospital at prevailing prices at each hospital during the same period. Some administrators may dissent on the grounds that such a method would still be inequitable, contending that large hospitals can provide food service at lower cost per capita than smaller ones. Experience will convince one that this is but a time-honored myth, if the management is efficient.

To those who question that the reputation of an institution is largely a matter of the food service, it is suggested that they inquire around a bit. Again and again it will be said: "I was treated well but the food was terrible."

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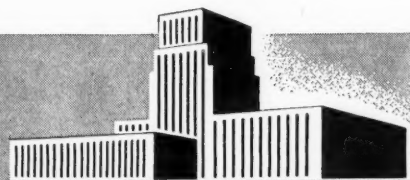
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# Future of Voluntary Hospitals

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Institute of Public Administration, New York City

**I**N VIEW of present trends toward broader responsibility on the part of the government for the care of the sick, it is possible that in the near future government may largely dominate the hospital service field, either directly through ownership, management and control or indirectly through the subsidy of nongovernmental hospitals.

The voluntary hospitals that make up the most important block of the nongovernmental institutions must have better support than is provided by fees from patients if they are to function efficiently for community health. It is difficult for the voluntary hospital without a large endowment to obtain adequate financial support except in the large communities where there is a considerable number of people in relatively high cultural, social and economic positions. The most efficient voluntary hospital enterprises with which I am familiar are those in communities where the general public endorses and supports the community chest or a similar plan for raising and distributing social contributions.

## Tax Funds Can Be Used

The government is in a more favorable situation and needs only to provide in its tax budget for the funds necessary to cover hospital needs. No one can escape the tax collector. This simplifies the problem of hospital financing and under such procedure hospital deficits are not so difficult a problem. Furthermore, the government is not compelled to collect its taxes for hospital support from any particular community or population group. Hence, the wealthy communities can be taxed to support hospital enterprises for the poor ones.

The voluntary hospital is also handicapped in having to adapt its plant and service to the special needs of the particular community or group that supports it.

The governmental hospital, however, need have no such limitations

of policy, plan or operation. It can serve a "district," which may include a number of counties, cities, villages, towns or other population units. Governmental hospitals are, in fact, usually planned to serve as large an area and population as is possible and practicable in order to take advantage of all opportunities for reducing costs. Other things being equal and within recognized limitations of size, the larger the hospital plant and the larger the population group served, the lower the unit cost and the better the service.

Furthermore, the governmental hospital, unlike the voluntary institution, is not under the necessity of planning and providing service to patients who represent a wide range of social and economic levels. The medical and nursing care offered by governmental hospitals should, of course, be of essentially the same high quality as that of all other hospitals, but many of the refinements of patient accommodations essential to the voluntary hospital's multi-level community service may be eliminated by the governmental hospital. Governmental hospitals may, therefore, be constructed and operated more cheaply without necessarily lowering the quality of professional services.

Other opportunities for reducing costs that are not easily available to the voluntary hospital are implicit in governmental hospital operation. The economies of centralized group management are more readily obtained. Centralized governmental financing practically compels centralized administration.

There is, however, another side to this question. There are distinct and, possibly, even greater advantages to democratic society in the maintenance and further development of voluntary hospitals. It is my experience, in the course of twenty-five years of study of both governmental and voluntary hospitals, that with but few exceptions a better quality of service is offered by the latter.

This does not result primarily from the special conveniences or the flexibility of the voluntary hospital in adapting its service to the needs of the individual patient, nor is it due to the fact that voluntary hospital expenditures per patient may be greater. It is because the voluntary hospitals are able to enlist for policy-making, management and operation an amount and kind of personal service along all lines that governmental hospitals can rarely obtain and are by their very nature handicapped in obtaining.


## Best Service Is Voluntary

The voluntary hospital comes into being most often because some philanthropic, socially minded individuals see a community health need that cannot be met adequately except by the voluntary cooperation and financial support of private citizens. The voluntary hospital organization that offers to provide this needed service is able to draw to its aid the best intelligence and the least selfish, most humanitarian cooperation of citizens. The greatest advances that have been made in America toward the realization of health security for all have, almost without exception, been initiated and fostered by private citizens and citizen groups, acting voluntarily and cooperatively, to meet a need that is either not recognized by government or is not within the government's lawful sphere of responsibility.

Government may be mechanically perfect in theory and once set in motion may function with high efficiency, but it rarely sets itself in motion automatically. Even in its most efficient state it begins to function in most instances after the stimulus has been applied from without and there is almost invariably a disheartening time lag.

There are many reasons for governmental tardiness in accepting new and better ideas, improved technics and procedures. Some of these reasons are to be found in partisan politics, in the exigencies of government financing, in legal anachronisms and limitations and, often, in the sheer

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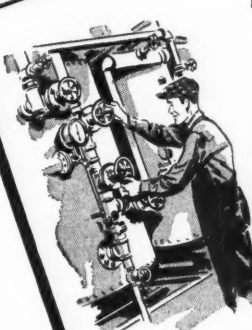
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inertia of the government agencies and the confusion of their objectives.

But there is another and more important reason. The governmental hospital has far less freedom to experiment than the voluntary hospital and, moreover, lacks the stimulus and cooperative action of an organized body of intelligent, unselfish citizens.

Another striking advantage of the voluntary hospital is its freedom from the personnel controls set up under rigid civil service regulations or some other application of the merit system. It is unthinkable that governmental hospitals should be without this safeguard. Although civil service is not and probably never will be a thoroughly satisfactory protection against serious abuses in governmental hospitals, it is the only safeguard available against the spoils system.

#### **Disadvantages of Civil Service**

Civil service often fails to provide governmental hospitals with a personnel endowed with the character and personality essential to the hospital purpose. It tends rather to the employment of hospital workers who regard themselves primarily as civil service rather than hospital employees. In other words, their interest is often more likely to be in the security of their jobs than in the opportunities and rewards of useful service. Finally, civil service appointees, even those who may be wholly unfit, cannot be easily dismissed.

If governmental hospital services are extended to nonindigent patients, it is reasonable to believe that the influence thereby exerted upon the entire hospital service field may not be encouraging to the vigorous growth of the voluntary hospitals. I believe this fact merits more attention than the voluntary hospitals have yet given it.

There will need to be closer cooperation among voluntary hospitals everywhere if their great assets are to be used most productively to maintain that needed leadership. There is more need than ever for the interest, advice, direction and support of hospitals by groups of citizens who have no political or other axes to grind and are concerned only in the perpetuation of the sound traditions of American social progress.

These social leaders believed, first of all, that true democratic humanitarianism was something that could

not be attained through political systems, no matter how comprehensive or beneficently intentioned. There is ample evidence in the world today that their ideal was not purely visionary. The splendid American system of voluntary hospitals is their monument. The problem of utilizing "social power" in place of "governmental power," which has been clearly defined by all great social leaders in our history, needs redefinition today. Leaders in the voluntary hospital field must again be looked to for guidance.

#### **Centralizing Authority**

Sound principles of organization and administration are as essential for hospitals as for other public services. Government generally has recognized that for best results related services should be coordinated under a single competent directing authority; that duplication and overlapping of function should be eliminated; that like functional services, such as record keeping, accounting, auditing, purchasing and general maintenance, should be centralized and standardized.

The voluntary hospitals have, however, in general continued to maintain their separate existences in most large cities without coordination of even those overhead services, facilities and procedures that are common to all and necessary to intelligent community planning and financing. Each hospital serves primarily the interests of its own particular social, religious or other group; each is served by its own select group of physicians; each maintains its own system of statistics, accounting, auditing, purchasing, collecting, public education and public relations; each provides its own independent units of plant, equipment and personal service; each conducts its own social service unit, training school for nurses, educational, recreational and other adjunct services; each maintains its own out-patient service in which may be duplicated a ridiculous number of special clinics.

The opportunities for cooperative and coordinated voluntary hospital community service are legion but in many large communities the voluntary hospitals continue to act as though they were competitors rather than partners.

It is not primarily because the advantages of coordinated voluntary

hospital work have not been seen by hospital associations and boards that they have been slow to undertake it. Rather, the religious or social origins and inheritances have become so revered and sanctified by the years that there is a reluctance to change. One can appreciate this point of view without endorsing it. Many times during hospital surveys, policies and procedures have been found in effect that had no application to today's problems and, although they were actually handicapping to progressive management, yet were retained out of respect for their original sponsors or because they were believed to give the hospital some peculiar distinction or prestige. Then, too, many voluntary hospital authorities fear that coordination may in some way hamper individual freedom. There is little real basis for such fear.

#### **Costs Can Be Lowered**

Voluntary hospitals, under the wise guidance of community or district hospital councils, can plan, construct and administer their services much more economically than they do at present. Voluntary hospital costs can be reduced. This is of paramount importance.

Granted this, under existing conditions in most communities voluntary hospital costs are, on the average, as low as is consistent with high quality service. But as long as there are readily discernible ways and means of further reducing these costs, which are not used, citizens in increasing numbers are likely to turn their eyes to other leadership. They are likely to call for greater extension of governmental hospital services and even for the establishment by government of controls over voluntary hospitals that will, I think, hamper rather than encourage true hospital progress in America.

Reduction of the costs of voluntary hospitals without impairment of the quality of their service will encourage wider use of voluntary hospitals, particularly by people in the low income groups. Extension of nonprofit hospital service plans will naturally be stimulated by such a lowering of costs. I firmly believe that the vast majority of people in all economic levels prefer voluntary to governmental hospital service and will use the former service more freely if it can be made available at lower cost.

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HOSPITAL



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# SCOTCH CONDENSING



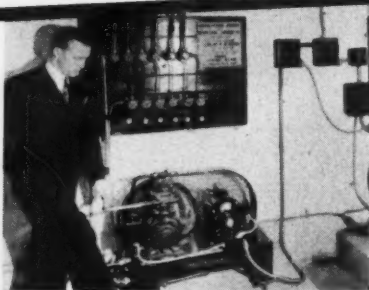
# GIANT UNITS

*rugged . . . powerful . . . dependable . . . thrifty*

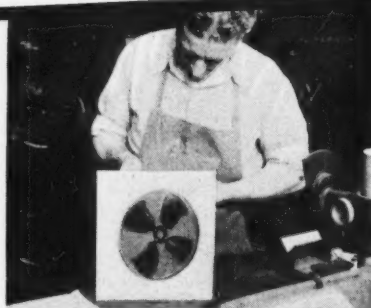
HERE'S HOW research, craftsmanship and mechanical precision are combined to make the G-E Scotch Giant the most efficient condensing unit you can buy for low cost operation.



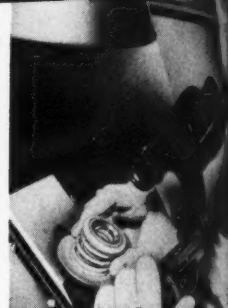
ireless Engineers—with the tremendous facilities and experience of the General Electric Co. at their disposal—ever striving to perfect methods... ways devising new improvements.



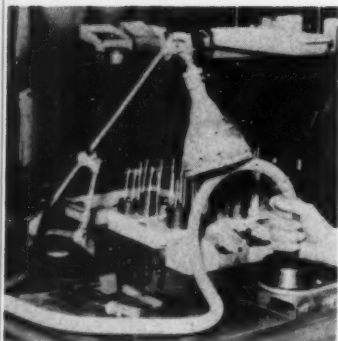
Right in the field are other G-E technicians testing, observing and compiling data for refrigeration advancements. From these testing grounds comes a wealth of actual "consumer" experience.



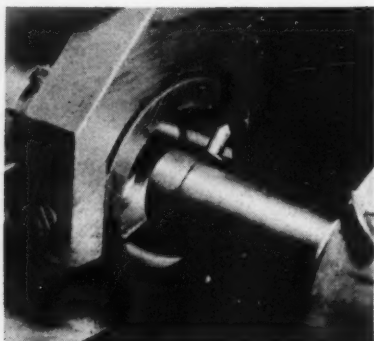
The aphonic fan is a typical example of such research. It is 15% more efficient and 40% quieter than ordinary fans. A streamlined shroud on the condenser helps distribute air flow uniformly.



Assembly of shaft seal is made in a dustproof room, and all parts are made through microscopes of balanced bellows type, designed to prevent leakage of refrigerant.



Valves are of polished Swedish steel. Assembly and test are made under full vacuum. ALSO: the use of plated upper gaskets prevents oil and refrigerant leaks, assures years of service.



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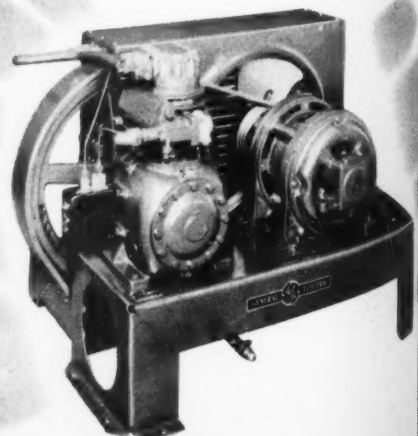
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## They Will Attend Meetings

RAYMOND P. SLOAN

HOW frequently we hear the complaint: "But they just won't take the time or the trouble to attend meetings. Yes, there are always some faithful ones to be sure, but they're in the minority."

Can it be possible that the fault may not lie with the board members at all but with the meetings they are asked to attend? Perhaps they did attend once upon a time and learned better—learned that it wasn't worth the effort, that they gained too little and lost too much valuable time. Further, they learned that if they did come all that was expected of them was to respond mechanically when the presiding officer droned, "All those in favor. . . ." Whatever issue was involved, it must be all right. Everyone seemed to think so, anyway.

Suppose we look in at some of the meetings that are taking place daily and see what the situation actually is. The first is being held in the lounge in a nurses' residence. No one could ask for more comfortable accommodations, a bit too comfortable, perhaps, judging from the sound of heavy breathing coming from the depths of an upholstered chair in one corner. It isn't wholly the fault of the chair or its occupant. The monotonous reading of a financial report will lull anyone to sleep. Why that same report could not have been mailed to members of the board in advance of the meeting or even after is difficult to explain.

Already we have one rule to remember in planning a board meeting: *Never consume time reading reports that can be presented more effectively in typewritten form.*

Next we enter the private dining room of a club where some 15 men are seated around the table listening to a committee chairman who has had the floor for twenty minutes. It's going on to 3 o'clock and these are busy men who have taken time out of the heart of their day to attend the hospital luncheon. No won-

der they're beginning to shift restlessly in their chairs, look at their watches and study the nearest exit. What's wrong with the presiding officer? He should know that you can't deliberately waste men's time, that is, not more than once.

Another rule for our list is then: *Guarantee every board member that the hospital meeting will be over at a certain time.* The luncheon meeting, for example, that starts at 12:30 should be adjourned no later than 2:30.

At its very start we sense something wrong with the third meeting. The scene is the board room of a large industrial concern that is centrally situated thus saving time for everyone. This is an excellent ar-

*will be expeditiously executed to save their time and sustain their interest.*

Numerous rules might be added from personal observation that resolve briefly to this: Express your appreciation to the board member who is willing to give his time by not wasting it. He is giving his interest and this interest should be sustained and stimulated. He should leave every meeting with renewed enthusiasm for the part he is playing in hospital affairs, rather than with a feeling of disgust at the pilfering of his precious time.

The selection of the proper place and time for hospital meetings rests with the individual institution. Undoubtedly, the most logical choice is the hospital itself, thus affording closer personal contact with the institution. Many times, too, committee meetings may be held before or after the trustees' meeting, thus saving members an extra trip. Such consideration will always be appreciated by busy trustees.

When the hospital is located at some distance from the center of business interests, it may not be practical to meet on the premises. This necessitates the designation of some other meeting point that will be convenient for the majority. Frequently, the private room of a club or a board room in some business organization is made available through the courtesy of a board member.

This arrangement works out satisfactorily, particularly if on one or two occasions each year the group assembles at the hospital for luncheon or dinner. It may be the occasion of the annual meeting, a Christmas celebration or the last gathering before the summer vacation period. It should be a gala event with emphasis on entertainment and good fellowship rather than on routine business. This is important in stimulating the interest of the board members.

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**Nobody can make trustees attend meetings, but it is entirely possible to make them want to attend and also to take an active interest in the hospital, the editor maintains**

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agement, yet, apparently, there are some confusion and misunderstanding about the order of business. As we enter, the presiding officer is holding a whispered consultation with the administrator and, with nothing else to do, the board members are discussing their golf scores or their latest hunting expeditions. It requires time to get them back to the subject of hospital work about which they know little or nothing. It does not look as if they were going to learn much, either.

Rule No. 3, then, reads something like this: *Before asking board members to attend meetings, be sure there are carefully planned agenda that*



Having selected the logical place for hospital meetings, there is the question of time. This must conform to the pattern of life within the community. Whether they take place at noon, in the late afternoon or during the evening rests with the habits of the majority. There can be no generalization.

The noon meeting, when it is feasible, has the advantage of getting men around the luncheon table where they can talk together while they eat, thus saving time and providing an atmosphere of informality. Many board members who find it impossible to divorce themselves from their business affairs any other time of the day can spare an hour or two at lunch. And how much less serious many problems appear following a palatable lunch and a good cigar!

It is for this same reason, no doubt, that some hospitals in which the officers or board members meet late in the afternoon or during the evening make a practice of serving tea or coffee with sandwiches or cakes. It creates good fellowship without which no board can function efficiently.

Hospital dinners had best be reserved for special occasions. They serve effectively as an extra attraction, but such catering inflicts additional burdens upon a department that too frequently is taxed to capacity.

From personal observation at hospital board meetings we have learned that all business must be dispatched speedily and efficiently, with the necessary facts and figures placed before members far enough in advance so that they may have the opportu-

nity to study them and to vote intelligently. The hospital president in conjunction with the administrator should have no difficulty in preparing agenda that will conform with modern business procedure.

One administrator has succeeded in keeping his trustees informed by issuing a little mimeographed sheet every month acquainting them with happenings of importance within the hospital—increasing occupancy, for example; a record achieved in the maternity department; a problem encountered in the boiler room; the situation in regard to delinquent accounts, and, possibly, a letter of endorsement from a patient.

This information is presented informally, so that the reader can get a definite picture of what is happening from month to month and will be prepared to discuss any of these matters that may be brought up in meetings.

Although strict observance of these principles will in itself promote interest, it is possible that time may be left for some feature that may be educational and stimulating. Fifteen minutes, no more, no less, given to a member of the medical staff to describe some outstanding contribution he has made to his profession will be instructive. If, for no other reason than to acquaint the trustees with their department heads, the nursing supervisor might be invited to say a few words about nursing problems or the dietitian asked to present interesting food facts. It may seem desirable even to introduce some outside speaker who has something of interest to contribute on the subject of hospitals and public health work.

The board of managers with the aid of the administrator might well supply its own entertainment by staging round table discussions. All that is required is that each member bring with him some question on hospital operation that he would like to have answered. Such a forum, with the president presiding and the administrator in charge, offers just one problem—it may be difficult to close the meeting on time.

Who says they won't attend meetings, these men and women who are giving generously of their time and money to our voluntary hospitals? They will, if the meetings are worth their while.

## WOMEN'S SERVICE GROUPS

### Hospitals in Rotogravure

• Again, the women's and junior committees of the Western Pennsylvania Hospital in Pittsburgh have met with great success with a rotogravure section published by the Pittsburgh *Post-Gazette*. Pictures taken in the hospital show the modern treatment of pneumonia and also the many services rendered by the social service group. This year, war flavors the hospital presentation with the story of blood plasma for shipment to England, hospitalization for the Navy, medical practice in the Army and the aid that is being given to Great Britain.

It is interesting to note what Mrs. Francis Crandall, the chairman, has to say about it. First she explains that the social service committee is composed of two groups, the women's committee and the junior committee, totaling more than 100. Both groups united in working on the rotogravure section for, as she puts it, "we feel that so much work is involved that it can only be successful when undertaken by a large committee."

"The paper was published in cooperation with the *Post-Gazette*," she continues, "the members of the committee selling the advertising and receiving a percentage of the gross receipts. Our percentage was on a sliding scale and we received a higher percentage as our lineage passed a certain amount. We sold advertising on a retail and national rate, our retail rate being \$55 per agate line and our national rate \$75."

"The paper was made up on a basis of 40 per cent editorial matter and 60 per cent advertising, and the content was planned and selected by the committee with the cooperation of the *Post-Gazette*. The publishers turned over for our use an office in their building, equipped with telephone, typewriter and desks, which we made our headquarters during the campaign. They also assigned to us the services of one of their salesmen to advise members of the committee on selling the advertising and on laying out the copy. Debutantes and prominent Pittsburgh women were available as models for advertisements without any expense to the advertiser. Our actual selling campaign covered a period of six weeks, but much preliminary work had to be done on lists of prospective advertisers."

"The rotogravure section was the second of its kind that we have done in cooperation with the *Post-Gazette*. This year it will be our only means of raising money to finance our social service department which has four paid workers."

### Lectures Support O. T.

• The Avery lectures, an annual series put on in Boston by the welfare committee of Children's Hospital, produced \$5500 last year. Of this impressive sum, \$3700 was given by the committee with the approval of the board of managers to complete the installation of new x-ray equipment and \$1800 went as usual to the entire support of occupational therapy for the year.

# Both nurse and patient appreciate the

## \*CASTEX RIGID BANDAGE CAST

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**H**OW MUCH EASIER it is to care for a bed patient in a CASTEX Rigid Bandage cast! The cast is so light that a patient wearing even a large cast can be turned easily—and the cast does not dust or crumble. It can be kept clean with soap and water—the CASTEX cast is water-proof.

Your doctors will appreciate the CASTEX cast's rigidity and its permeability to x-ray. And the ambulatory patient enjoys the convenience of the light yet strong, water-proof CASTEX Rigid Bandage cast.

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*\*For use of hospitals and the medical profession only. CASTEX Rigid Bandage, the modern cast material, is composed of Alkyl Cellulose, Pyroxylin, C.P. Boric Acid, C.P. Acetone (a volatile solvent), Surgical Gauze.*

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RESEARCH TO IMPROVE TECHNIC, REDUCE COSTS



## Maintaining X-Ray Equipment

EDWARD W. WHITE

Chief X-Ray Technician, Albany Hospital, Albany, N. Y.

NOT so many years ago the x-ray department occupied an obscure corner of the hospital. It was a bare forbidding room strung with an array of wires, meters and crackling tubes, which were diagnostically efficient up to a point but which at times were allowed to reach a state of disrepair that not only reduced their efficiency but presented a menace to both patient and operator.

The modern x-ray department occupies a more convenient location in the hospital. The examining rooms and offices are bright and cheerful; all equipment is installed and arranged for maximum efficiency. Technical procedures are precise and consistent. The department as a whole is a well-organized and highly specialized unit of the hospital.

Maintenance of this x-ray equipment is a subject that, considered from all angles, covers a great deal of ground and has grown in importance in proportion to the development of more powerful, highly refined and, hence, more complicated equipment.

The most important consideration is expense, always, of course, keeping in mind that maximum efficiency must not be sacrificed to economy. Then, the size of the hospital, the amount of work done, the type of equipment, the number of people employed and the number of units in operation, all have a direct bearing on the subject.

First, we might consider the small hospital that has only one machine on which not more than three or four exposures a day are made. It is obvious that this machine does not deteriorate as rapidly from use as one on which 30 or 40 exposures are made daily. There are a number of factors to be considered in the department with a single unit. Dust, dirt and corrosion are always at

work. The overhead tubing may sag, filament connections become loose, cord reels lose their spring tension and the wires become frayed. Dust will collect on insulators and in damp weather may spark over. This is true of all glass surfaces, such as open tubes, tube bowls and rectifiers of either the mechanical or tube type.

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**The maintenance of x-ray equipment is no job for an amateur, warns Mr. White, in setting forth the ills that are likely to beset this complicated apparatus**

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The filament stabilizer may burn and get out of adjustment; synchronous timer contacts will pit and crack and cause delayed timing cut-off.

The technician in such a department is not trained in the many mechanical factors concerned with the operation of x-ray apparatus, so that, aside from a daily dusting and a thorough weekly cleaning of all accessible surfaces, the maintenance of such equipment should be left in the hands of a service representative of the manufacturer who, by a pre-arranged agreement, makes a periodic check and inspection of the whole unit at least every ninety days.

In a department in which there are three or more units in operation, the problem changes somewhat. Here will sometimes be found a variety of makes of equipment, some of which are much in use while others are allowed to decay in peace. This happens because the staff of any department will tend to use units that at all times produce the results they de-

sire. The other so-called "orphans" fail because of certain acquired characteristics which in many cases could be remedied at a nominal cost.

We are likely to find technicians whose knowledge of radiography is excellent but whose knowledge of electricity and mechanical ability are inadequate. Maintenance in a department of this type would necessitate service calls by representatives of three or four manufacturers. Although a keen interest may be shown by the staff in making minor repairs, lack of knowledge might, and probably would, run repair bills up and necessitate more expert service.

The staff should be trained and supervised by someone who has an adequate knowledge of the workings of all the units used and is trained to realize the importance of cleanliness; to prevent the dangers of accumulated dust; to recognize that the Bucky oil motor "skips" because of air in the oil cylinder, and to note any change in the sound of the unit or the action of the meters.

This training should include the ability to recognize and diagnose certain irregularities in the operation of a unit, such as grid lines on the films because of the lack of synchronism of the Bucky interlock with the timer, unusual densities or lightness of a short exposure owing to impulse timer flashover or lag, unusual lightness on one half of a film because of improper alignment of the stereoscopic shift device, or one light film of a stereoscopic pair because of a "cranky" tube.

To understand the characteristics and capacities of the x-ray tubes in use necessitates a thorough knowledge of filament increment curves, heat storage capacities and thermal equilibrium values so that tubes will not be operated beyond their limitations, thus shortening the life of the tubes or terminating it abruptly.

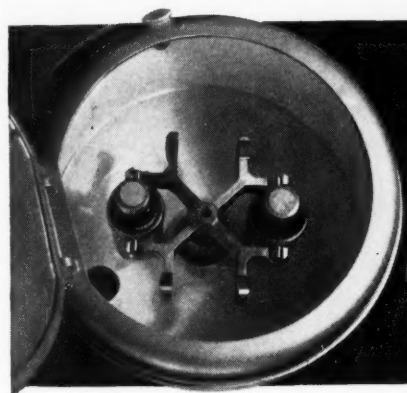
In the large hospitals, especially teaching institutions, the problem as-

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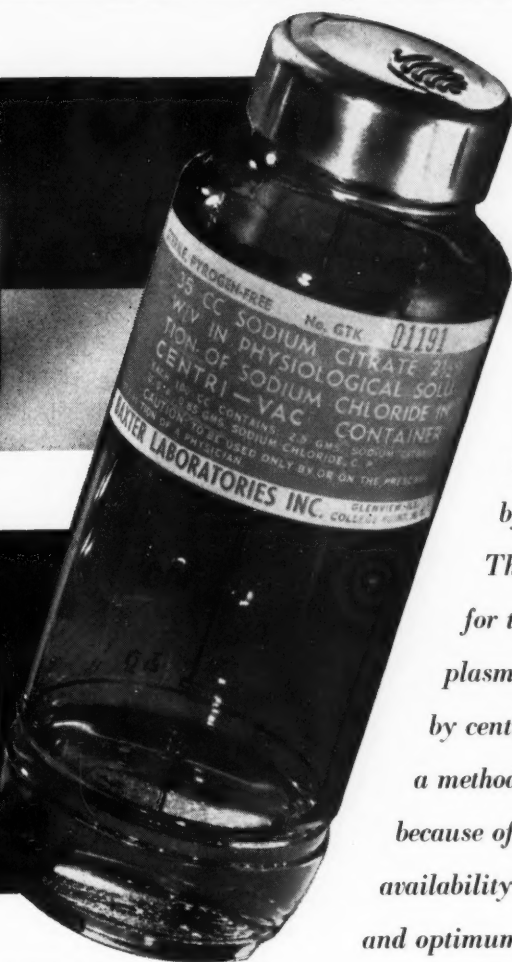
*one vacuum container  
for both  
Sedimentation and Centrifugation*



**sedimentation** ☆



**centrifugation**



★ THE Baxter CENTRI-VAC because of its tall cylindrical shape and small diameter, has proved to be a most satisfactory container for the preparation of plasma by sedimentation.

This shape makes it also ideal for the preparation of plasma or serum by centrifugation—a method preferred by many because of its maximum yield, availability for emergencies and optimum clarity.

☆Serum cannot be prepared by sedimentation, it must be centrifuged.

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sumes greater proportions, because more highly specialized work is done. Obviously, this necessitates specialized equipment and unusual accessories either purchased from a manufacturer or made in the hospital shops.

All of this, together with modern, high powered multi-milliamperage

units utilizing rotating anode tubes, high speed Bucky diaphragms, high voltage therapy units and multi-plane fluoroscopes, again broadens the scope of maintenance.

In the interests of economy, the x-ray department should employ a technician who is thoroughly trained in all phases of x-ray design, con-

struction, theory and practice. He should be responsible for the efficient operation of all units and should plan his work to cover the following points:

1. A daily check of filament readings for various milliamperes; line voltage of all machines, particularly the therapy units; milliamperage readings of all fluoroscopes, and inspection of any high or low tension wiring that might endanger the safety of the patient.

2. A weekly check of all structural details for loose nuts and bolts; stereoscopic shift devices; cassette changers; main and limit switch contactors; gear and brake units of tilting tables; milliamperage ratings, especially if a rotating anode tube is used; focal spot switches, and filament stabilizers.

3. A monthly check of contactors, relays, oil switches and pilot lights; contacts and action of thermal relays and overload circuit breakers; Bucky oil motors; cord reels; filament connections to tubes, timer contacts and automatic controls for spot film devices.

4. A radiographic calibration of the machine with the aid of a spinning top and aluminum step penetrometer whenever it seems to be indicated. Such a test will be an accurate check on the timer, will record the quality of radiation from the tube, will detect a faulty rectifying tube and will show any mechanical inefficiency in the x-ray transformer or autotransformer.

Maintenance costs of an x-ray department are greatly influenced by the intelligent cooperation of the staff, based on sound practical and theoretical knowledge.

The staff should be trained to recognize the x-ray unit as an important scientific instrument and to treat it as such. It should be constantly alert for little troubles before they suddenly grow up to be big and expensive ones.

In all institutions a periodic check should be made by a competent representative of the manufacturer whose equipment is in use to ascertain the condition of parts of the equipment that are not ordinarily accessible to the staff and to help prevent serious breakdowns. Such inspections also keep the technicians informed of recent changes and improvements in equipment.

## Storage Space on Wheels

A MOBILE storage system that increases the available storage space by almost 50 per cent has been developed in England and was featured in a recent issue of the *Hospital* (London).

The mobile units, equipped with bins, shelves, racks and rails, run on rails that can be sunk into a low platform. Each unit is capable of being set in motion at a touch and a row of 10, fully loaded, can be moved with one hand. The general practice is to arrange them in depths of three or four rows.

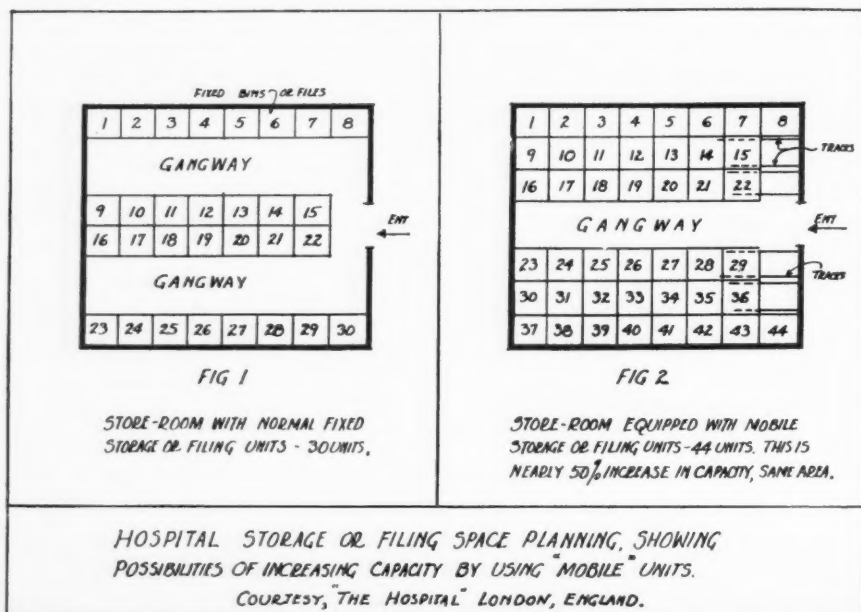
Each unit is made easily accessible by moving the units in the row immediately in front of it sufficiently far apart to permit passage. There is no risk of injury. The units travel at low speed and buffers are fixed at the top and bottom of the ends to prevent the sides from coming into direct contact, as well as to afford finger room.

In addition to the benefits that this system presents from the point of view of quick transfer or inter-

changeability of stock, there is the further great advantage that the elimination of the need for a gangway between every two rows saves floor space. Where there are several storerooms on each floor, there is the further advantage that the respective storerooms can be interconnected by rails and the supplies can be unloaded from the truck or trolley at a central position where empty storage units await filling.

The need for the decentralization of storage under wartime conditions, in order to minimize the damage and sudden shortages resulting from partial destruction by air raids, renders these mobile units of particular value at the present time in effecting quick distribution from main to auxiliary storerooms.

Instead of the contents of one or more rows of shelves being emptied onto hand-propelled conveyors and then another set being filled up elsewhere, the transfer can be effected merely by removing the requisite number of units in their entirety.



IT'S THE LITTLE TOUCHES THAT MAKE BIG HITS!

HOW THOUGHTFUL! MY  
FAVORITE KELLOGG CEREAL  
IN AN INDIVIDUAL  
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"With Kellogg's Individuals, we're sure our cereals are fresh, clean, and appetizing. They save work and waste and help us control costs."



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There's good will and good sense in serving Kellogg's Individuals. Good will because the patient has her choice of 8 Kellogg cereals . . . served in an attractive, appetizing way. Good sense because Kellogg's Individuals increase breakfast variety without increasing work, because they permit accurate cost-control and eliminate waste.

Just be sure to specify Kellogg's Individuals when you order. Your grocer always has a fresh supply. Packed 50 Individuals or 100 Assorted to the case.

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CHOICE OF—

**Kellogg's CEREALS**  
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# Angles on Air Conditioning

## Good Practices and Bad

LEWIS E. JARRETT, M.D.

Director, Hospital Division, Medical College of Virginia, Richmond

**A**IR CONDITIONING for operating rooms has been hailed in many quarters and by many people as of distinct value to both the patient and operating room crew, as well as in the improvement of the quality of surgery. Surgeons, more or less generally, have proclaimed air conditioning as a necessary aid to their work. After observing a form of air conditioning for operating rooms for six years, I am sure that conditioned air has a definite value, but at the same time there are certain dangers that must be reckoned with.

In the last two or three years much has been written on the subject and the committee on air conditioning of the American Hospital Association has brought in excellent reports.

Six years ago the surgical staff of the Hospital Division of the Medical College of Virginia, Richmond, insisted that some form of air conditioning be installed in the operating rooms because of an unusual number of postoperative infections. It was argued that the operating room was on the third floor of an almost obsolete building adjacent to the main thoroughfare of the city. It was thought that dust entered through open windows and the extreme temperature in this locality prohibited operating with the windows closed. Even at that time a new hospital to replace the existing institution was contemplated and it was agreed that an elaborate system was out of the question.

### Individual Units Selected

Our consulting engineer insisted on a central system with duct distribution to all of the rooms involved. Another engineer felt that individual cooling units for each room with a central compressor would be entirely satisfactory. The cost of one system was estimated at \$8000, while the other was \$2600. The committee in charge decided on the latter unit and installation was made at once.

In my opinion this system accomplished only one purpose, that of cooling, while at the same time a number of objectionable features

were uncovered. It is true that the cooling increased the comfort of the operating crew and probably that of the patient. This, to my mind, did not help to prevent infection but, strangely enough immediately after the installation, postoperative infections fell to a minimum level and have remained below any normal expectancy ever since.

The only explanation for this condition seems to be in the fact that the windows of the operating room on the main thoroughfare were tightly closed, and this belief was corroborated by several bacteriological studies.

### Danger of Recirculated Air

Although this phenomenal result was fairly convincing, the installation was somewhat unorthodox and dangerous in a number of respects. In the first place there was no fresh air brought into the room except by seepage, making the entire system a recirculation of air with no fresh air being added except the amount that naturally enters any room. Because of this fact there was a rise in the CO<sub>2</sub> content of the air, as well as a concentration of the various volatile anesthetics used, neither of which would be advantageous to the operating crew or to the patient. This system had a thermostat to control temperature but there was no regulatory mechanism for the control of humidity.

This we now recognize as extremely dangerous; the control of humidity is really one of the most important points in connection with any system. Mechanism could not be installed for this purpose so the next best thing to be done was to place a humidistat in the room and to instruct the nurse to cut off the unit should the relative humidity get as low as 55. This procedure was followed for five years and the results were exceedingly satisfactory. There were no apparent reactions

from patients after they left the surgery and were transferred to their rooms in which the temperature was several degrees higher. A number of patients were closely questioned along this line and their remarks were entirely negative.

The new hospital is equipped for winter air conditioning throughout and for summer conditioning of the operating room floors. The cooling system is designed so that it can be expanded to other floors when it seems to be desirable.

This system brings in fresh air and there is no recirculation of air. Dehumidification is accomplished by chemical means, thus decreasing the cost of the system. The cooling is accomplished almost entirely by water from two 6 foot wells that furnish water at 50° F.

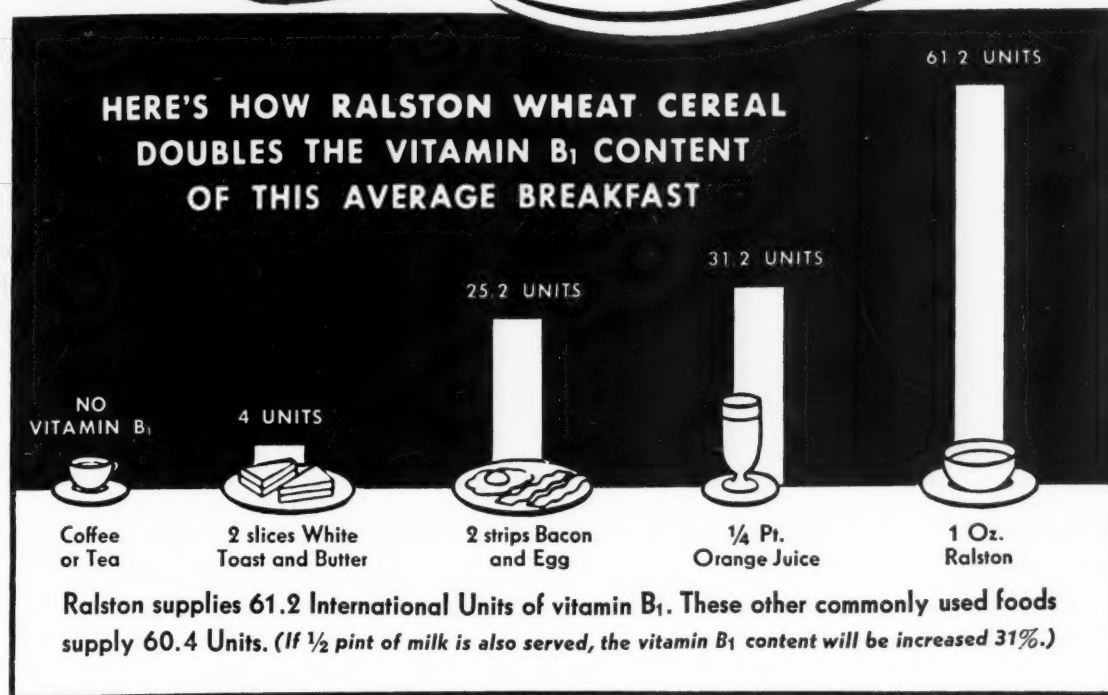
The patient is made comfortable, therefore, with air of extremely low humidity that requires little cooling. In other places, where low humidity is dangerous, comfort for the patient and workers is achieved by a combination of low humidity and low temperature.

In the operating and delivery rooms we have installed recording devices for registering humidity and temperature at all times. This is thought necessary both for future studies and for the protection of the hospital in case of accident.

### Air Conditioning in Demand

In general, it seems that air conditioning is being demanded by the public in connection with almost every type of business and the hospital must fall in line with the trend as rapidly as possible. Surely no hospital should be planned at the present without giving proper consideration to this subject so that future installation can be economically effected. This is particularly true of the hospitals of the South where extreme temperatures are encountered in the summer months.

## An A-1 way to increase vitamin B<sub>1</sub> in breakfast



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Enriched with extra quantities of natural wheat germ, each ounce of Ralston supplies 61.2 International Units of natural vitamin B<sub>1</sub>... considerably more than whole wheat itself and much more than most other wheat cereals. In addition, Ralston supplies the carbohydrates, proteins, phosphorus, iron, bran and other valuable food elements found in natural whole wheat.

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**Ralston**  
puts the B<sub>1</sub> in Breakfast



## Kitchen Equipment on Parade

MARIE FERGUSON

Executive Dietitian, Alameda County Hospitals, Oakland, Calif.

**G**ENERALLY speaking, most institutional kitchens have a basic similarity in general plan, beginning with the receiving of the raw food and progressing to the finished meal. The thought that the kitchen is built primarily to serve customers or patients must be given first consideration in making plans for this area.

### Merits of Decentralization

Decentralized service has several advantages. Kitchens are placed in accessible locations on each floor of the hospital and each is fitted with equipment consisting of broilers, stoves, refrigerators and general service equipment. The greater part of the food is prepared in the main kitchen and transferred to each of these service kitchens where it is placed in the steam table, refrigerator and cabinets.

Broiled steaks or chops or other especially cooked food reaches the patient in excellent condition if enough help is available to move it to the rooms promptly. It is possible to delay a tray for some time when the patient is not ready to receive it.

The trays can be given individual attention in order to please particular patients. It is also possible to order and receive nourishments at almost any time owing to the location of these various service kitchens. The finished trays are either carried individually to each patient or are loaded on tray carts and moved down the corridor and distributed from there.

Decentralized service has some real disadvantages, however. Each kitchen occupies space that might be used as a patient's room and, therefore, curtails revenue. It is necessary to distribute food from a main kitchen

into each service kitchen, with a resulting higher food cost. It is extremely difficult to control food costs properly and to supervise the service because it is spread over the entire hospital.

Decentralized service requires that each service kitchen be equipped with a broiler, a range, a steam table, coffee urns and refrigerator, which, in most cases, are small and do not have the efficiency of the larger, higher grade equipment that is usually placed in a large centralized kitchen. Duplication of equipment is expensive as to its first cost, its fuel cost and its maintenance.

These disadvantages can be practically eliminated by using a centralized food service and it has been found, also, that the advantages of decentralized service can be duplicated by proper installation of a centralized kitchen. To accomplish this, the hoisting apparatus should be centrally located and of rapid action. The serving and cooking equipment, in relation to the hoisting apparatus, should be placed in a position where a maximum of service can be rendered with a minimum amount of waste motion.

The entire personnel of the food service department should be well organized and especially trained to perform special duties quickly, quietly and efficiently. This organization should include the medical and nursing staffs because their cooperation will help materially in having their patients ready to be served at the proper time.

The methods of delivery from a centralized kitchen are by dumb-waiter, subveyor or elevator, all of which have been greatly improved in recent years.

If they are transported by dumb-waiter or subveyor the trays are sent to a selected floor, from which point

they are either distributed individually or are placed in carts for distribution.

If elevators are the means of transportation the trays are loaded in tray carts, hoisted and then moved down the corridor for distribution. In the case of the dumb-waiter, with an average capacity of five or six trays, an attendant must receive and remove the trays on arrival. On the subveyor, each tray moves immediately to its destination. In this case, also, an attendant removes the trays. The subveyor runs up at the time of service, one set of flight bars immediately following another, so that the trays can be loaded quickly without interruption, provided the distributing service is properly organized.

Subveyors are reversible and in their descending travel deposit the trays on a belt that automatically carries them to the dishwashing tables. They are also equipped with selective service push button controls so that the trays will not rise above the selected floor. If trays are not removed they automatically stop the machine and, when removed, the machine automatically starts again.

The tray cart service by elevator can be varied by using either heated or unheated carts. The heated carts require a segregation of cold food and permit loading a greater number of trays on each cart, the cold food being placed on the tray when the tray is removed.

### Floor Area Determines Service

The selection of one of these methods of delivery depends entirely on the area and length of the corridor of each floor of the hospital. A building that is laid out with long corridors would probably be best served with trays loaded in carts for these long distance deliveries. If the hospital has a smaller floor area, with short corridors, either a subveyor or dumb-waiter would render the best service.

Presented at the Western Institute for Hospital Administrators, 1940.

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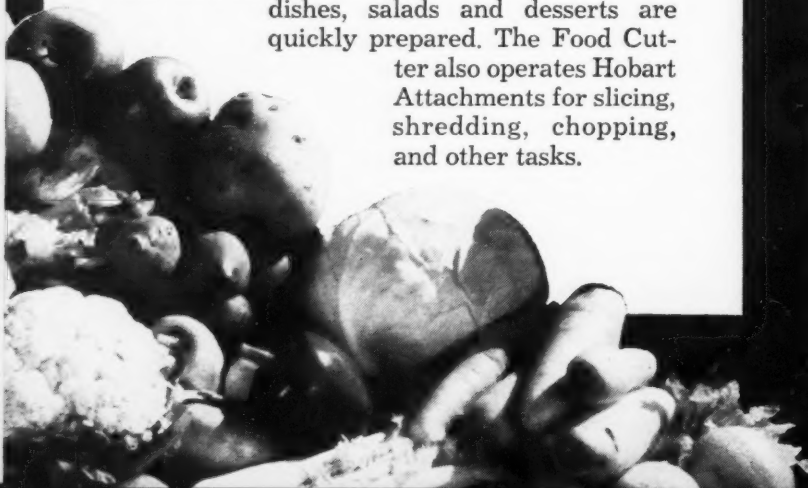
You can influence the public's impression of your institution very directly—through food and service that build good will with the individual patient. Tempting, delicious varied meals and special diets attractively served with sparkling clean china, glass and silverware, will be appreciated and remembered. Hobart Food Machines play a vital part in helping you carry out your program for distinguished service in this department. The swift, economical help they afford is always on the job.

# PUT HOBART ON JOBS MEANT FOR MACHINES!

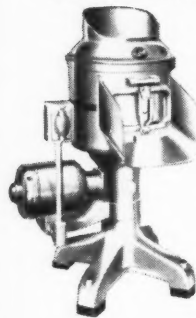
### SPECIAL, ATTRACTIVE FOODS SPEEDILY, EASILY PREPARED



A Hobart Food Cutter can be one of the most widely useful machines in your kitchen, in helping create scores of delicious specialties. It cuts and mixes all kinds of foods uniformly, at lightning speed, and with absolute safety. The materials for soups, vegetable or meat dishes, salads and desserts are quickly prepared. The Food Cutter also operates Hobart Attachments for slicing, shredding, chopping, and other tasks.



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Hobart Peelers peel just "skin deep." They reduce peel loss to the minimum. They do not waste all the valuable mineral salts that lie just beneath the potato skin. Potatoes are served often and in a variety of ways—whipped, escalloped, Julienne, parsley buttered, riced, browned, French fried. This popular Hobart Food machine also peels or cleans other root vegetables. Four sizes (from 8 up to 45-lb. capacity) bring potato peeling savings to every kitchen, whatever its size requirements.

# HOBART FOOD MACHINES

MIXERS • DISHWASHERS • FOOD CUTTERS • SLICERS • PEELERS

After a delivery system has been planned, the food service, kitchen and dishwashing equipment should be placed as close to the means of transportation as is practical in order to eliminate unnecessary steps.

The generally accepted service of a large hospital resembles a cafeteria wherein the tray is set up as rapidly as it is delivered and requires attendants who place each article or group of articles, such as tray cover, salt and pepper shakers, sugar dispenser and silver, on the tray and send it on to receive the hot and cold food.

Dish heating facilities, plate covers and other auxiliaries to this service should be placed either below the service rail or above it so that they can be easily reached by the attendant.

A small hospital that does not have a large personnel would probably use tray racks and partially set up the trays in advance of the meal hour, adding the hot or cold food at the time of serving.

The service equipment itself has not changed materially in its fundamental design for years but has been greatly improved by the use of better metals, such as stainless steel or monel metal, and by refinements and changes in design that can be attributed to the welding processes.

#### Improvements in Design

Doors on new equipment are now supported on ball-bearing rollers that leave the lower guide bars open so that spilled food will not accumulate and eventually stop the smooth operation of the doors. It has also been possible, through changes in design and construction, to eliminate the use of angle iron and band iron almost entirely. The body material can be formed into channels and electrically welded so that not only the band and angles but bolts, nuts and rivets are eliminated. This leaves the fixture with a clean, streamlined appearance and also makes it easy to clean.

The improved equipment includes such items as ceramic tile gas broilers and toasters, conditioned air refrigerators, ice cream freezers and gas-fired steam cookers. The new gas broiler has been improved by using special ceramic tile refractories that are placed over the gas burners where they become glowing red and almost white. Improvements have

also been made in the grids and in the grid raising and lowering devices.

Having heard a discussion of the infra-red rays, as used by the medical profession for applying heat in the treatment of disease, it occurred to me that this ray was in evidence in this broiler. We found on investigation that this ray does emanate from glowing ceramics and that at a wave length of one micron it has a penetration into flesh of about half a centimeter. While this maximum penetration is probably not developed in this broiler, we still are certain that we do get a penetration in addition to the surface or conducted heat. This gives different results in broiling; it is also possible that broiling over charcoal or with electrical units results in the same penetration, depending upon the whiteness of the heat.

There is now available an efficient gas-fired steam cooker that is equipped with a porcelain liner and with a water pan placed in the bottom, under which large gas burners operate. There are flue spaces at both sides and at the back of this steamer through which the excess heat is carried off.

This is similar to the construction of an ordinary gas oven and the result is that the chamber fills with steam from the boiling water and the temperature is raised considerably above ordinary steam temperature because the heat from the flues develops an interior temperature that can be brought up to approximately 275° F., depending upon the amount of gas that is burning at the time.

The temperature of 275° F. is equivalent to a steam gauge pressure of 30 pounds. The result of this higher temperature is that foods retain their natural coloring, as well as a higher percentage of natural mineral salts, owing to the drier steam and, therefore, retain their flavor and nutritional value to a greater extent than was formerly possible.

#### Toaster Operates Cheaply

The ceramic tile gas toaster is not new but has proved its value for large hospitals because it is available in large sizes and operates so cheaply that it can become standard equipment for all such institutions. The toast from this toaster has a little different character from that made by other methods because the toast

first enters a heat area where it goes through a drying process and then receives the final toasting as it passes through the ceramic tile heater.

One of the greatest of the recent improvements in hospital kitchens is the use of conditioned air evaporators in refrigeration. Manufacturers have improved the refrigerators by providing them with rounded corners and edges and making them either of metal coated with porcelain or lacquer or of stainless steel.

The application of conditioned air has made it possible to maintain the inner air at a high degree of humidity, which naturally does not permit dehydration of foods. In a hospital kitchen this applies particularly to the storage of desserts, salads, butter and cream. Storing them in refrigerators until they are served thoroughly chills the plates, as well as the salads, so that the salads reach the patient in crisp and appetizing condition.

The conditioned air evaporators are well adapted to the counter type of refrigerator because they occupy little space and force the air into all areas of the box. These evaporators operate at approximately 33° F., at which point the humidity in the air does not freeze onto the coils, thus obviating the necessity for defrosting them. Some humidity clings to the coils in the form of water, which washes the air and retards the transfer of food odors.

#### Ice Cream Stays Solid

The serving of ice cream in hospitals has been quite difficult because if it is served with the tray it partially melts and becomes unsightly before the patient has finished the rest of the meal. It recently occurred to us that it would be possible to pour ice cream into china dishes of special shape and size while the cream was still in a semiliquid state. If these dishes with the cream were stored in hardening cabinets, the result would be that the dish itself, as well as the ice cream, would reach a low temperature. The temperature of a hardening cabinet is lower than that of an ordinary ice cream dispensing cabinet. This temperature could be regulated to meet the demands of each hospital, allowing for the time required for the distribution of the trays and the time needed by the patients to eat the rest of the meal.



# This Business of Guest Trays

## To Serve or Not to Serve

THERE are few dietitians who are not called upon on occasion to serve guest trays. Such service may be frankly discouraged if it places too great a burden upon the dietary department or it may be developed definitely as a feature of the public relations program.

The presence of coffee shops or pay restaurants within the building is a most satisfactory solution—unquestionably a boon to the dietitian as well as to the nursing department and even, at times, to the patient. Should room service still be required, it can be handled chiefly through the coffee shop, leaving to the dietary department the matter of catering to patients and employees, which is its primary function. The coffee shop or hospital restaurant minimizes, therefore, if it does not completely eliminate, the problem of guest trays, which is one of many points in its favor.

While admitting that the guest tray presents problems, most dietitians are ready to acknowledge that it builds good will. Therefore, they serve them within reason, that is, provided that such service does not interfere with the food service to the patient.

According to a survey conducted among dietitians in hospitals large and small throughout the country, prices for guest trays served to private rooms range from as low as 50 cents for breakfast to \$2 for a holiday dinner. The average is 50 cents for breakfast, 75 cents for lunch or supper and \$1 for dinner. Seventy-five cents is about the lowest price reported for dinner.

In some of the larger metropolitan hospitals \$1.50 is the usual dinner charge, with breakfast costing 75 cents or \$1. In other institutions a flat price of \$1 is charged for every meal, whether it is breakfast, lunch or dinner. Some hospitals jump the price for holiday dinners, while others take this opportunity to build good will by urging private patients to invite guests for dinner, which is served them at no charge.

Usually, guests are urged to make their selection from the regular

menu, special orders or substitutes being discouraged. Elizabeth Rupert at Hackensack Hospital, Hackensack, N. J., encourages her guests to take what is on the regular menu, permitting them, however, such substitutions as a sandwich, chops or ice cream. In one or two instances à la carte meals are served and charged according to the items ordered.

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**Guest trays, while valuable in building good will, constitute a problem in more ways than one. That problem can best be solved by the hospital coffee shop or the cafeteria**

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Some hospitals will serve foods that are not on the regular menu, but at an extra charge, while others state emphatically: "The guest is not allowed to order special foods; only those appearing on the regular menu are served." One dietitian even lets it be known: "We never make an exception to this rule."

Ward guest trays are served only where some unusual circumstance would seem to warrant them.

"Occasionally, we serve tea and toast or sandwiches as a courtesy to relatives who cannot leave a patient," Bertha B. Ashley of St. John's Riverside Hospital, Yonkers, N. Y., says. "We do not consider this a guest tray, however, and no charge is made." In fact, Miss Ashley does not serve guests trays anywhere in the hospital unless there is good reason—a mother staying with her child, for example; a relative who does not want to leave a seriously ill patient; an elderly visitor, or an anniversary celebration.

"A few years ago," Miss Ashley relates, "there were no restrictions, with the result that we were serving many extra trays and our food service

was greatly overtaxed. Our hospital is located within easy reach of restaurants, a factor that we took into consideration before discouraging requests for guest trays. We find it best to have exceptions approved by the administrative office, which relieves us of the embarrassment of refusals. Sometimes guest trays are served on holidays to ward patients who have been hospitalized over a long period or to friends or relatives of ward patients who are critically ill."

Some hospitals, however, have a regular charge for guest trays for semiprivate and ward patients. One of these lists breakfast and supper for 35 cents, a regular dinner for 50 cents and a holiday dinner for 75 cents.

The question of guest trays at Mount Sinai Hospital, New York City, is discussed on a card that is distributed to all patients in its private pavilion. Helen Somers, supervising dietitian, quotes it as follows:

"Although the hospital is not equipped with dining room facilities to furnish meals to visitors, a guest tray selected from the daily menu will be served at a fixed price if sufficient notice is given in advance of the meal service. Arrangements may be made for this service through the head nurse on each floor.

"Breakfast is served from 8 to 8:30 at a cost of \$1; dinner, from 12 to 12:30 at a cost of \$1.50, and supper, from 5:30 to 6, also for \$1.50. The usual variety of sandwiches and such beverages as coffee, tea, milk and cocoa are served during the same hours as the regular meals and also after 3:30 in the afternoon at a charge of 50 cents. Sandwiches are toasted on request, but facilities for serving them hot are lacking. Cookies may be substituted for a sandwich at the same price and any dessert on the daily menu may be added for an extra charge of 25 cents."

Fortunate, indeed, are those dietitians who have within the hospital a coffee shop to aid them in the problem of food service to guests. In

# Learn Why Patients and Hospitals Alike Prefer This Special Libbey Tumbler

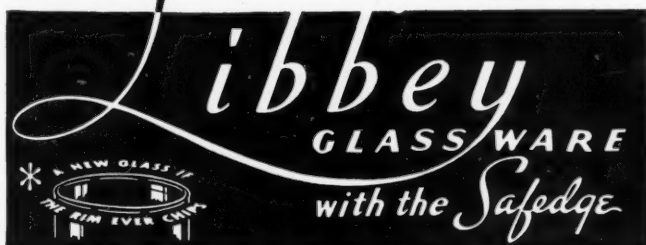
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Photograph by Vernon Lewis, Irvington, N. J.

**A coffee shop is a great help in solving the problem of serving guest trays.**

such institutions the guest tray becomes purely an accommodation and is discouraged. Lucille Waite, chief dietitian, California Hospital, Los Angeles, tells us, for example, that the prices in the coffee shop are less than those of their guest trays and this alone is sufficient to discourage guests from ordering trays to the patients' rooms.

"Before the installation of the coffee shop," Miss Waite asserts, "we served a great many guest trays and it was, indeed, a nuisance."

Dietitians, with but few exceptions, attest to the value of guest trays as a means of building good will. While admitting the importance of such service, some add that it is difficult to estimate its value. Miss Somers believes that it has at least avoided possible criticism. "However, in a city like New York," she explains, "most of our visitors have their homes near by and there are excellent restaurants within a short distance of the hospital. For these reasons, the demand has been small."

"On occasion a visitor wishes to take a meal in the hospital with a wife or husband and has asked for this accommodation. The visitors and patients who want this service appreciate it, I am sure, and to this extent, perhaps, it helps to maintain good will."

"The question of guest trays is a definite problem," states Ethel Lewis Marth, administrative dietitian,

Highland Hospital, Rochester, N. Y. "Some provision should be made for these people, especially when restaurant facilities are not available in the community. We find that the serving of guest trays builds good will with the public and patients. However, plans are being laid for a coffee shop or guest dining room in Highland Hospital, which will take most of this burden off the nurse in charge of food service on each division."

A word of warning is voiced by Bertha B. Ashley. "Guest trays, within reason, can help to build good will. On the other hand, the patients' food service must be of first consideration and the amount of good will created by the serving of an unlimited number of guest trays will be lost if it detracts from this service."

There is no doubt in the mind of Mary K. Bloetjes of the Hospital for Joint Diseases, New York City, that serving guest trays creates a feeling of good will among the patients and their guests.

"It is a question of how this income should be credited," Miss Bloetjes adds. "Our guest meals are credited as meals served to the group whose guests are served. For example, a meal served to a private patient's guest is counted in with private patient meals. The income from guest meals is credited to general hospital income and is not credited to the dietary department or deducted from the cost of patient food."

"With hospitals filled to capacity," Elizabeth Rupert points out, "and with additional guest trays to serve, it is also a question of having adequate silver, linen and dishes. It is more satisfactory to have a paying dining room where the guests may be served."

## FOOD FOR THOUGHT

### Cost per Meal

The cost per patient and employee per meal at Ancker Hospital, St. Paul, for 1939 was 16 cents. Based on food purchases only, the cost was 10 cents. The 16 cent figure is based on total operating expenses of the dietary department. What is your per patient and employee cost?

### Help on Breads and Cakes

How to obtain the best results in baking and points to observe to prevent failure are included in "Breads, Rolls, Waffles and Muffins for Quantity Cookery," by Alice Easton, published by the Dahls, Haviland Road, Stamford, Conn. This little Gold Book, priced at 50 cents, contains many basic quantity recipes the average being 24 portions. The same helpful information applied to cakes, cookies and cake icings is also available in Gold Book No. 34.

### Meat Recipes

The American Meat Institute in Chicago sings a song in praise of the value of meat in the balanced diet in its new brochure "Medley of Meat Recipes." The clever booklet, which is distributed by the National Live Stock and Meat Board, 407 South Dearborn Street, Chicago, contains recipes for roasted, broiled, braised and boiled meats, as well as suggested menus and a table of vitamins found in various foods.

### Food Film

A nation-wide nutrition education campaign was recently inaugurated by the U. S. Public Health Service with the showing of a ten minute technicolor film, "Proof of the Pudding." The picture is designed to show the foods that are needed to form the structure that supports good health. It will be released to commercial theaters throughout the country.

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# May Dinner Menus for the Small Hospital

Lenora Weber

Dietitian, Bloomington Hospital, Bloomington, Ind.

Day	Meat, Fish or Substitute	Potatoes or Substitute	Vegetable	Salad or Relish	Dessert
1.	Broiled Lamb Chops	Mashed Potatoes	Frosted Peas	Raw Carrot and Pineapple Salad	Caramel Custard
2.	Baked Trout	Parsley Butter Potatoes	Stewed Tomatoes	Celery Hearts and Olives	Fresh Strawberry Bavarian
3.	Swiss Steak	Baked Potato	Harvard Beets	Asparagus Salad	Honey Dew Melon
4.	Swedish Meat Balls	Mashed Potatoes	Baby Lima Beans	Tomato Slices	Cottage Pudding, Chocolate Sauce
5.	Roast Chicken	Candied Yams	New Asparagus	Waldorf Salad	Brick Ice Cream
6.	Veal Liver and Bacon	Creamed Potatoes	Whole Green Beans	Leaf Lettuce and Endive, French Dressing	Sliced Peaches
7.	Rolled Beef Roast	Boiled Potatoes, Brown Gravy	Peas and Carrots	Pineapple and Cheese Ball Salad	Coconut Cream Pudding
8.	Ham Loaf	Escalloped Potatoes	Whole Kernel Corn	Coleslaw in Beet Cups	Gingerbread Squares, Green Apple Sauce
9.	Broiled Halibut With Lemon	Mashed Potatoes	Buttered Broccoli	Head Lettuce, Thousand Island Dressing	Apricot Whip
10.	Roast Veal	Browned Potatoes	Summer Squash	Sliced Oranges	Rice Custard
11.	Sirloin Steak	Diced Creamed Potatoes	New Peas	Tomato Gelatin Salad	Peach Betty
12.	Chicken Fricassee	Tiny Potatoes, Parsley Butter	Glazed Carrots	Fresh Fruit Plate	Frozen Lemon Custard
13.	Beef Stew	Egg Noodles	Buttered Diced Beets	Carrot, Celery and Turnip Sticks	Blueberry Pudding, Lemon Sauce
14.	Veal Chops, Mushroom Sauce	Baked Potato	Wax Beans	Apple and Grapefruit Wedges	Chocolate Blancmange
15.	Meat Loaf	Spaghetti in Tomato Sauce	Succotash	Lettuce Hearts, French Dressing	Fresh Cherry Cobbler
16.	Salmon Steaks	New Potatoes, Melted Butter	Creamed Celery	Apples and Olives in Lime Gelatin	Frosted Strawberries
17.	Ham Slices	Browned Hominy	New Spinach With Lemon	Banana and Nut Salad	Spice Cake
18.	Sirloin Roast	Mashed Potatoes	Tomatoes With Bread Cubes	Cabbage and Green Pepper Salad	Soft Custard Over Bananas
19.	Creamed Chicken on Toasted Bun	Baked Stuffed Potato	New Asparagus	Honey Dew Melon and Orange Sections	Chocolate Ice Cream
20.	American Chop Suey	Steamed Rice		Mixed Green Salad	Gelatin Cubes With Whipped Cream
21.	Roast Leg of Lamb	Mashed Potatoes	Creamed Carrots	Pineapple Ring With Mint Jelly	Bread Pudding, Caramel Sauce
22.	Round Steak, Cream Gravy	Boiled Whole Potatoes	Harvard Beets	Shredded Lettuce, Boiled Dressing	Applesauce
23.	Baked Haddock	Creamed Potatoes	Fresh Kale With Lemon	Beet and Egg Salad	Grapenut Fluff
24.	Meat Loaf	Escalloped Potatoes	Buttered Green Beans	Molded Fruit Salad	Chocolate Brownies
25.	Beef Liver in Tomato Sauce	Potato Balls, Parsley Butter	Buttered Corn	Leaf Lettuce, Cream Dressing	Baked Custard
26.	Baked Chicken	Mashed Potatoes	Buttered New Peas	Tomatoes on Water Cress	Fresh Strawberry Sundae
27.	Chopped Steaks	Macaroni, Mushroom Sauce	Baby Lima Beans	Raw Carrot and Cabbage Salad	Melon Slice
28.	Rolled Roast	Browned Potatoes	New Spinach	Mixed Fruit Salad	Tapioca Cream Pudding
29.	Virginia Baked Ham	Mashed Sweet Potatoes	Wax Beans	Celery Hearts and Radishes	Bananas in Orange Gelatin
30.	Salmon Loaf	Baked Potato	Creamed New Peas	Shredded Endive, French Dressing	Prune Whip
31.	Beef Stew and Vegetables	Light Dumplings		Perfection Salad	Pineapple Upside-Down Cake

Recipes will be supplied on request by The MODERN HOSPITAL, Chicago.

# "We saved \$64 a year

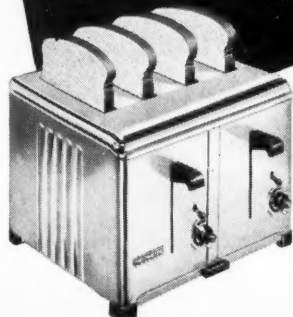
by trading our old toasting  
equipment for the **MODERN**

## Toastmaster Toasters\*\*



\*Actual on-the-job tests by dietitians and food service operators have proved that money wasted operating obsolete toasters will pay for Modern TOASTMASTER TOASTERS! If you trade in your old toasting equipment before June 15th, your new toasters will cost you less . . . you'll cut your toasting costs as much as 40% . . . you'll serve better looking, better tasting toast . . . fresh, hot and delicious for every tray!

**WE'LL GIVE YOU A  
LIBERAL ALLOWANCE  
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McGraw Electric Company,  
Toastmaster Products Div., Elgin,  
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master" trade-marked fully auto-  
matic Toasters, Bun Toasters, Roll  
and Food Warmers, Waffle Bakers.

### SAVE MONEY WHEN YOU BUY IT . . . SAVE MORE WHEN YOU USE IT!

#### SAVE UP TO \$33 ON YOUR NEW TOASTERS!

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Your bills will go down because Modern TOASTMASTER TOASTER requires less wattage, uses current only in slots that are actually at work!

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You eliminate costly repairing of old equipment when you have a new Modern TOASTMASTER TOASTER!

**SAVE SPACE!** You'll need less than a foot of space to turn out even 435 slices an hour with Modern TOASTMASTER TOASTERS!

### SEE THE DISPLAY AT ALL LEADING EQUIPMENT DEALERS . . . AND GET FULL DETAILS OF THIS TRADE-IN OFFER!

Made in 2, 3, 4, 6, Duo-8, 12 and Duo-16 slice models—capacities 110 to 870 slices per hour! Also TOASTMASTER BUN TOASTERS for hamburger buns.



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City..... State.....  
My dealer is.....



## All Set for Summer

MILDRED BURT

Executive Housekeeper, Mountainside Hospital, Montclair, N. J.

WITH the days rapidly growing longer, the advent of spring is at hand and, consequently, we shall soon find ourselves making plans for summer in the housekeeping department. Some of the problems that will confront the housekeeper are summer vacations, renovations, decorations and inventories.

Unlike the home housekeeper, who plans to clean and renovate her home thoroughly in the spring, the hospital housekeeper has to wait for a more auspicious time. She must do much of her specialized work in the summer, when the hospital census is lower than in the spring months and, thus, cause as little inconvenience as possible to patients and visitors.

The matter of summer vacations is one of the problems that cause the housekeeper's brow to wrinkle and her hair to become gray. However, the most effective way to solve this difficulty is to use a sort of "flying squadron," a group of four, six or eight extra maids and porters. The number will depend on the number of employees to have vacations, the amount of vacation allowed and the time over which the vacation period extends. The formula seems to be something like this: the number of employees times the number of weeks in a vacation divided by the number of weeks over which vacations can extend equals the number of substitutes needed.

With 48 employees, a two week vacation period and the vacations extending through a twelve week period (say, from June 1 to August 31), the formula would work out to eight substitutes.

If the vacations are arranged so as to begin on a two week cycle, it is ordinarily a comparatively simple matter to assign ahead of time on a vacation schedule blank the members of the "flying squadron" in



Wall washers should have early vacations so that they will be on the job during July and August.

rotation to the places for which they seem best fitted.

It may be a bit upsetting while the new employes are getting settled in their various jobs but after a day or two comparative quiet ensues for a two week period or until it is time for the next change to be made.

There will be changes in the schedule before the summer is over, no doubt, but it is something to start with and is a great help in getting the members of the substitute group properly settled.

Insofar as it is practicable, it is worth while to give the employes a choice of time. It is well, when possible, to let employes have their vacations at the same time that other members of their families will have theirs or to let those who are married and have children have their vacations while the children are out of school.

In a hospital that employs colored help, it is often possible to get supe-

rior young people who are going to college and who need to earn some money to help them through the coming year. It is usually possible to employ the same ones for two or three consecutive summers, thus reducing the number of new workers to train in any one summer. Then, too, among those substitutes who are not going to school in the fall, it is often possible to find good prospects for permanent work.

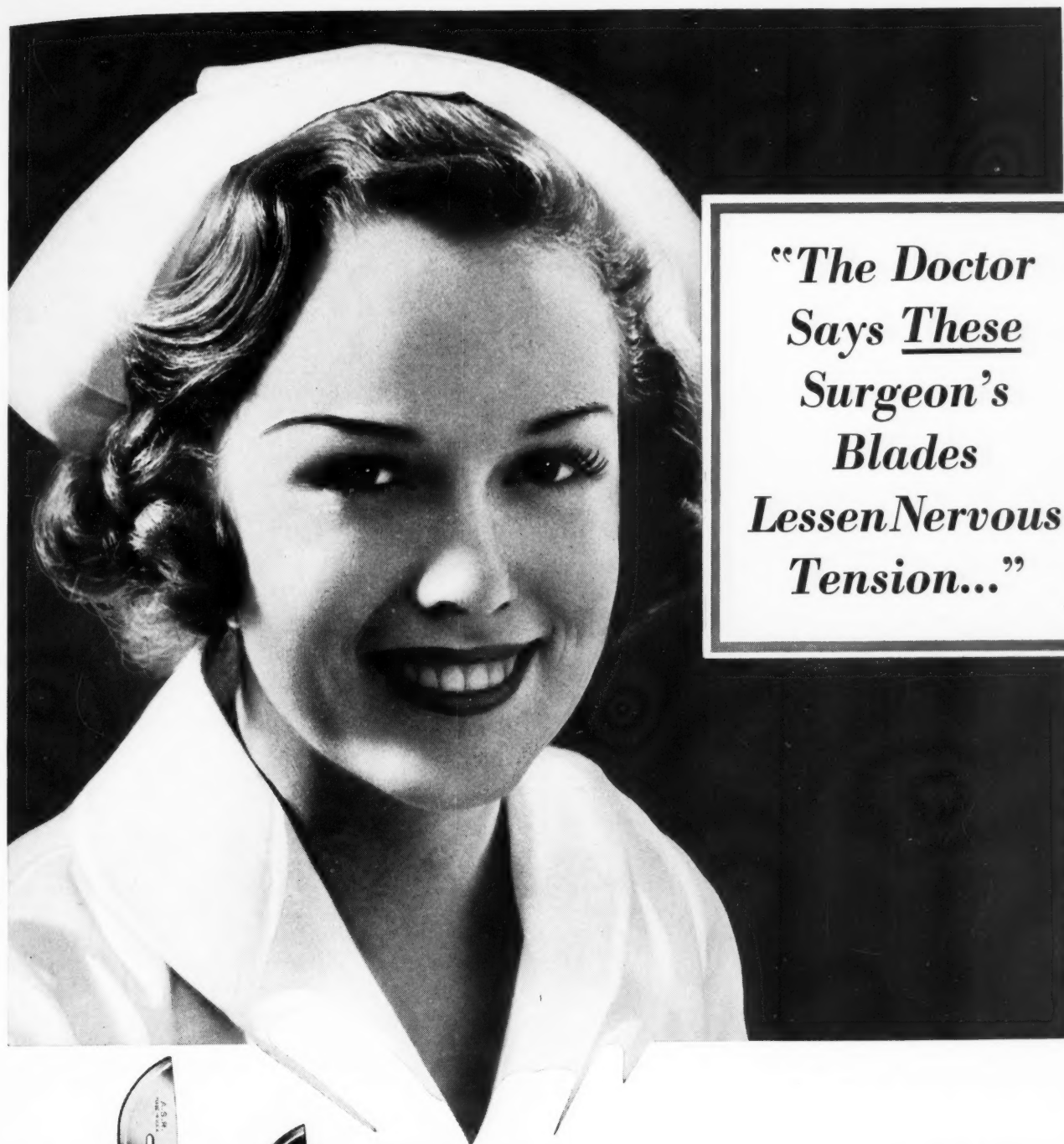
Because of the opportunity that summertime affords for specialized work, particularly for wall washing, it seems to be a mistake to use the wall washer for a vacation substitute during the summer. That is the time of the year when wall washing can be done to the best advantage, since more private rooms are empty, classrooms are unused and many of the nurses are away on vacation. The wise housekeeper will plan for the wall washer to have an early vacation so that he will be back on the job during July and August. In this way, she may push "full steam" ahead on the cleaning of walls.

Baseboards can be scrubbed; leather furniture can be washed with saddle soap; where needed, special treatments, such as sealing and waxing, can be given floors.

When redecorating is necessary (and what hospital does not need it?), it can undoubtedly be done best during the summer. Not only may there be fewer patients in the hospital than in the spring but the number of visitors is lessened so that such work can be carried on with a minimum of interruption.

Linen and bedding inventories may be taken during the summer and, without question, it is the best time of the year for making the blanket inventory.

Thus, the alert housekeeper will find many prospects which will need special attention in the summer time, and which, if carefully planned and carried out, will ensure for her a more smoothly running department when the busy days of fall and winter arrive.



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# War Declared on Pests!

MABEL AGNES BAILIE

Resident Director, Rockford College

**T**WO kinds of pests that bring sorrow into the life of the hospital housekeeper remain to be dealt with in this series of articles. They are bedbugs and mosquitoes.

## *Bedbugs*

There is only one species of bedbug that habitually attacks man and establishes itself in his living quarters. The differences in appearance in these bugs are due mainly to the amount of food they contain.

The food of bedbugs is the blood of warm-blooded animals, principally man. They are normally nocturnal except when they infest furniture in rest rooms in stores, theater seats, desks in offices and similar locations that are not frequented by man throughout the night.

Habitual hiding places of bedbugs are usually made evident by the disfiguring spots that stain surfaces upon which they rest. There is also an offensive odor, the result of an oily liquid emitted by the insect.

There is no better way to stamp out an infestation than by fumigation. This should be done by experienced persons as some fumigants are deadly poison to human beings. The advantage of fumigation over sprays and liquids is that the vapors enter the cracks and crevices and kill the bedbugs and their eggs.

When fumigation is out of the question ordinary fly sprays are fairly dependable when applied by a power sprayer. Liberal applications of clear gasoline brushed onto the furniture or put into cracks and crevices are sometimes effective. If possible, this ought to be done outside and all fire hazards must be eliminated.

## *Mosquitoes*

There are several varieties of mosquitoes in most localities in which these insects are troublesome. Domestic mosquitoes breed in great numbers in towns and cities; in fact, because of their severe annoyance to man, they often constitute quite a problem in large cities.

Since all mosquitoes breed in water any drain pipes in basements or in

hydraulic elevator shafts, fire buckets or unused toilets must be treated. A weekly spraying of such breeding places with No. 2 fuel oil will help to control breeding until the pollution situation can be permanently overcome.

When mosquitoes gain access to a house or other building, a thorough treatment with an effective spray is advised. This can be made of 2

ounces of No. 20 pyrethrum to 1 gallon of highly refined kerosene. An electric sprayer is advised, although some success may be obtained by using a hand sprayer. The rooms should be closed for ten or fifteen minutes. The air should be well filled with a fine spray mist. Since mosquitoes hide away behind pictures, under furniture and among clothing in closets, all such hiding places should be reached by the spray. Sprays will also kill mosquitoes on screened porches but here even more thorough application is necessary. It is best to sweep up and destroy the paralyzed mosquitoes because some of them may revive later.

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## THE HOUSEKEEPER'S CORNER

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### **"Wash Leather"**

When is chamois skin not chamois skin at all but nothing more nor less than sheepskin? Most of the time, according to a reader who has investigated carefully and assures us that there are practically no skins on the market today that are tanned from the chamois goat hide, for the simple reason that the chamois goat is practically extinct.

Chamois skins, it seems, originally were produced from the skins of the chamois animal but today are really produced from the skin of sheep, most of these sheepskins being imported.

The inner lining or flesher is split from the sheepskin while still in the raw state. It is then impregnated with cod oil, which is oxidized in the skin, causing the change in the skin fiber known as tanning. After the surplus oil is removed, the skin is buffed to produce a soft finish and cut to size and shape. This is the general process in producing domestic skins.

The point determining the principal difference in chamois skin quality is based usually on the treatment by which the tanning process is accomplished. The French tanned chamois, made from selected skins and tanned by hand, is the best in quality, and only the finest grade of fresh green sheepskin fleshers are used.

In order to give the user the greatest amount of wear, the skins are buffed or finished only on the flesh side. This gives them greater absorbing, as well as wearing quality. Although the unbuffed side sometimes appears rough when dried, the skin when soaked in water will be as soft and pliable as any of the thinner double dressed skins.

The hand tanning process gives an ability to pick up water and to retain pliability that machine-processing will not equal.

In the United States, all chamois skins are tanned from pickled skins, or skins packed in a salt and vitriol solution. When ready for preparation, these skins are washed and "plumped," that is, increased in thickness so that they can be put through the splitting machine which separates the outer portion of the skin from the "flesher" or inner portion. It is from the flesher that the chamois skin is produced.

The tanning process calls for highly skilled workmanship, as an overtanned chamois is as bad as an undertanned one. Perfect skins are products of skill and long experience. Chamois skins, therefore, are really sheepskins tanned by special process. Truly the correct name is "wash leather."

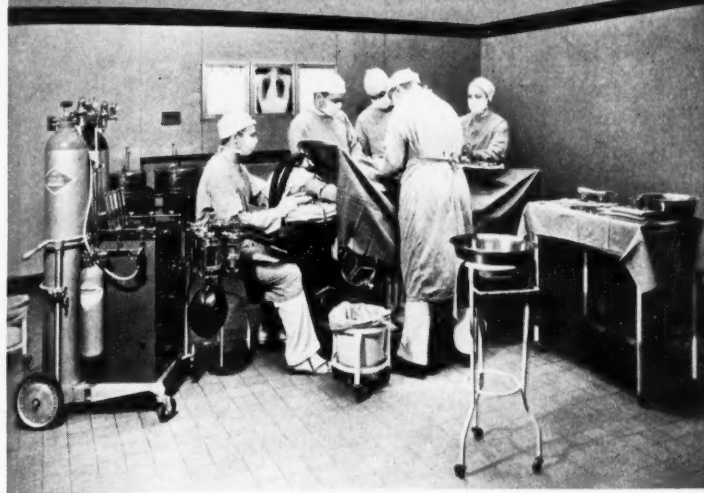
### **Kerosene for Floors**

An authority attests that floors will not need to be cleaned with water at all, provided they are waxed or treated with a high grade of oil containing cleanser.

Deodorized kerosene or some other high-grade petroleum product is often used as one of the ingredients of the best quality of oil and cleanser. High grade kerosene alone, in fact, is a good cleanser for oiled floors if it can be properly deodorized and protected against oxidation. "It really combines with the old dirty oil to form an emulsion and brings the oil from the pores of the wood to the surface where it can be removed. Kerosene has an advantage over water as a cleaner, in that it serves as a good preservative."

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# FAULTLESS



# *Hospital Pharmacy*

## Do's and Dont's for Pharmacists

EDWARD SPEASE

Director, Professional Relations, National Association of Retail Druggists

**T**HE pharmacist's duties are likely to vary with the size of the institution in which he is located. It is not necessary to enumerate those that are well known to everyone but there are certain responsibilities that devolve upon the pharmacist that are worthy of special comment.

The pharmacist, of course, is in charge of all activities of the pharmacy; he must be its executive officer and assign duties to all in his employ. As he is responsible for employees, their work must be reported to and clear through him.

He is responsible for prescription filling, pharmaceutical manufacturing and dispensing.

If he is not the buyer, he must be required to prepare specification for every item carried and issued as he is legally responsible for the quality of drugs and medicines and for the serviceability of other items.

### **Tact in Handling Purveyors**

He must know all purveyors of the items he carries and must be familiar with their catalogs. He must know how to eliminate purveyors of questionable items without provoking criticism of him or of his institution. He should not allow himself to be used to obtain clinical data for firms that do not have laboratories or a scientific staff. He must not be susceptible to gifts and entertainment offered by those who have an end to gain.

He must know and understand not only the advantages but also the dangers of quantity buying.

He must inspect all medications in the institution outside of his pharmacy and make proper recommendations therefor.

Laboratory reagents, both for routine and for teaching medical students, should be furnished by him.

He should see to it that drugs on floors or wards are kept in condition

and that the list of them is reduced to a useful minimum.

He should have control of all gauze, cotton and professional stores and issue them to the central dressing room or other places where they are required.

He should have inventories, prices and a location stock book of all items in the pharmacy. This is in addition to institutional systems of stock control.

He should have charge of the manufacture of all sterile solutions when the institution is large enough to warrant their manufacture; otherwise, he should inspect and store them.

He should have charge of teaching and research, if any is done within his pharmacy, and must learn that the out-patient department is no place for undergraduate students.

He should see that all narcotics, liquor and dangerous drugs are properly safeguarded and that all records and reports required by law are made.

In small hospitals he sometimes is placed in charge of general stores; sometimes he prepares specifications for them; sometimes he is the buyer; sometimes he teaches the uses of drugs and solutions to nurses, and might profitably be employed in teaching or demonstrating prescription practice and how to choose medications to interns or medical students.

The pharmacist should be able to give talks to various departments within the hospital, demonstrating where the pharmacy can contribute to or cooperate with these departments. He must know his relationship to each one of them.

He should recognize it as his duty to initiate professional conferences with staff members in regard to new medications and new combinations of old ones and to point out where

changes in routine medications and professional stores items will result both in better service and in monetary savings.

He should be alert to initiate procedures that will stop waste. An example now practiced in many hospitals, and thought of by a pharmacist, is that of reclaiming silver from x-ray waste solutions.

He should keep some sort of record, in some cases for given periods of time and in others perpetually, of everything done by the pharmacy so that he can prepare an annual report for the administration showing services rendered and savings made, together with recommendations for the future.

He should urge the adoption of a drug policy that will give the patients official and accepted medications and will eliminate high priced proprietaries under fancy names. A similar procedure is now possible for professional supplies.

A pharmacy committee or a therapeutics committee made up of one member of each staff department, such as medicine, surgery, pediatrics and obstetrics, should be created with the pharmacist as its secretary.

### **Committee Should Govern Policy**

The function of the committee is to pass upon every item stocked in pharmacy or professional stores, both additions to and deletions from stock; to approve such procedures in which these items are involved, and to make recommendations to the proper authorities upon how the pharmacy should be conducted.

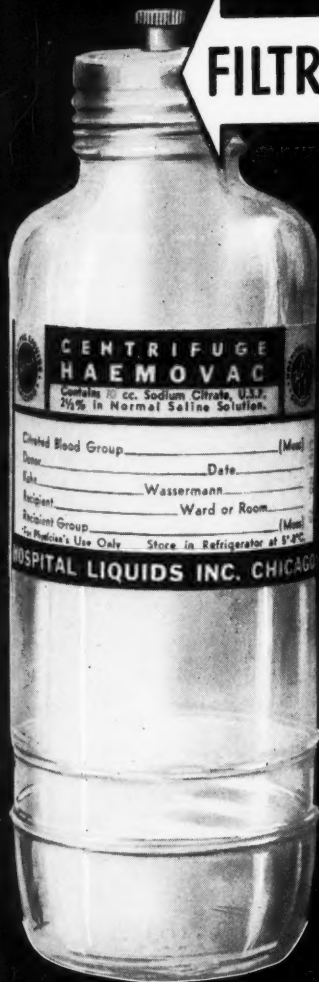
The committee should adopt a drug policy and a professional stores policy and, with the help of the pharmacist, should prepare a formula based upon rational therapy.

The hospital should recognize that the pharmacy is for professional service and should not prostitute it by including items of various types that are not of a professional nature.

## FILTRAIR SEDIMENTATION HAEMOVAC

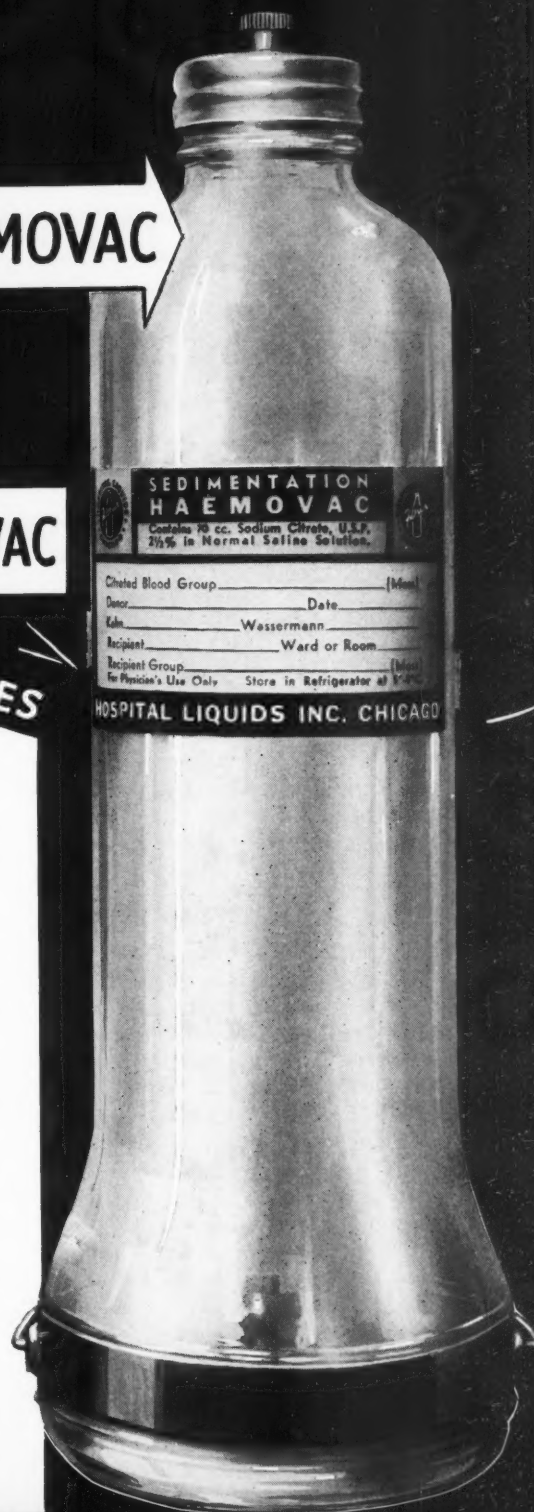
## FILTRAIR CENTRIFUGE HAEMOVAC

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No drugs or medications should leave the pharmacy except upon the written prescription of a physician aside from items that are routinely furnished to departments upon requisition. No prescription should be refilled without the consent of the physician who wrote the original one and no medication should be sold or recommended directly to patients, to employees or to any outsider without a prescription from a physician.

If a hospital is not chartered as a nonprofit or charitable institution, it may legally indulge in any sales that do not contravene law. If it is a nonprofit or charitable institution, it should not indulge in direct sales to former patients, to physicians, to nurses, to outsiders or to employees. Employees should not be permitted

to buy medications or other items from the pharmacy for themselves and their families and friends. A special clinic should be maintained for employees and their prescriptions should be filled free or at slightly above cost.

No home-going prescription and no prescription filled for the private practice of a physician, who by courtesy has an office in the hospital, should be filled at a price lower than that made for the same service in a reputable pharmacy.

No physician should be permitted to help himself to medications or instruments or to obtain medications to dispense to private patients outside the hospital for a smaller price than is extended to him by reputable pharmacies and surgical supply houses.

increase the storage of the lead in nontoxic form. Conversely, a low calcium diet and a low serum calcium increase the mobilization of lead into the blood in toxic form, where it may produce additional damage to delicate structures, such as the nerves.

Likewise, any altering of the acid base balance of the blood through the administration of acids or alkalis or even by febrile disease tends to remobilize the stored lead and restore it to the circulation in toxic form; hence, the treatment of lead poisoning with vitamin D, calcium salts and milk.

### Experimental

- Kehoe and his co-workers at the University of Cincinnati have recently placed the entire problem on a firm foundation by studying accurately the lead output of normal individuals when definite small amounts were added to their daily diet.

In three normal subjects on a normal diet the urinary lead averaged 0.30 mgm. daily and the fecal lead averaged 0.32 mgm. daily. By increasing the dietary lead intake by 1 mgm. daily of lead acetate, they found that most of this is not absorbed and that 1 mgm. daily can be tolerated for three and one half years. Also, daily ingestion of 2.0 mgm. of lead acetate for one year failed to result in any demonstrable effect on the health of the one experimental subject used.

The lead elimination was greater with 2 mgm. than with 1 mgm., indicating that the body is not definitely limited in the amount of lead that can be excreted. Since the average dietary lead of adult citizens in the United States is between 0.10 mgm. and 2.0 mgm., they conclude that a sufficient factor of safety exists in relation to the lead content of the general food stuffs of the United States. This does not, however, allow for the accidental ingestion of larger amounts of lead in specific industries where the incidence of lead poisoning is known to be high.

### Possible Race Poison?

- Chronic lead poisoning is unusual in that it may have a marked effect on the offspring who are not exposed. Germ cells of both sexes are affected. Among women exposed to lead there is a remarkably high percentage of sterility, miscarriages and stillbirths. Where birth does occur normally, the infant mortality rate during the first year is exceptionally high. Even where women are not in contact with lead, the toxic exposure of the husband has its effect. Thus, we must ever be on the alert for toxic effects of by-products of our industrial civilization.—CARL PFEIFFER, M.D.

## NOTES AND ABSTRACTS

Conducted by **Carl C. Pfeiffer, M.D., F. F. Yonkman, M.D., Arnold J. Lehman, M.D., and Harold Chase, M.D., Wayne University, Detroit.**

### Menace of Lead Poisoning

Alert physicians have learned to suspect that the following workers might possibly develop lead poisoning: painters, sanders, steel cutters and welders; storage battery workers and rubber goods workers; miners and smelters of lead ore and pottery workers; gasoline workers; insecticide sprayers; roofers; linotypers; plumbers, and solderers. Poisoning has also occurred from burning old storage battery casings as fuel, from drinking water conveyed through lead pipes ( $PbCO_3$  formed), from finely divided bullets lodged in the soft tissues of the body and from the use of lead foil on food wrappers.

Children have been poisoned by gnawing on cribs, toys or window sills painted with lead-containing paints; by the use of lead nipple shields on the part of nursing mothers; by playing on the floor when the father of the family emptied the cuffs of his trousers after working in an industry employing lead; by playing with lead soldiers or, worse, operating a casting outfit for making lead soldiers; by the use of lead acetate in the treatment of skin diseases; by colored chalk dust, and possibly by the mother's milk where her lead intake was high.

While the public at large is not in danger of being poisoned by any single source of lead, the government is constantly on the alert to determine if the increasing use of lead in many forms

might exceed the daily tolerance of our ability to excrete this cumulative poison. Lead arsenate fruit sprays, for instance, may be combined with a liquid adhesive so that the rains will not wash them off. The Department of Agriculture then suggests that if rain water will not wash the apples clean neither will the careful housewife remove all of this poison by a single washing. This single source would not be cause for alarm but, combined with lead from the exhausts of our motor cars and other sources, it might result in serious intoxication.

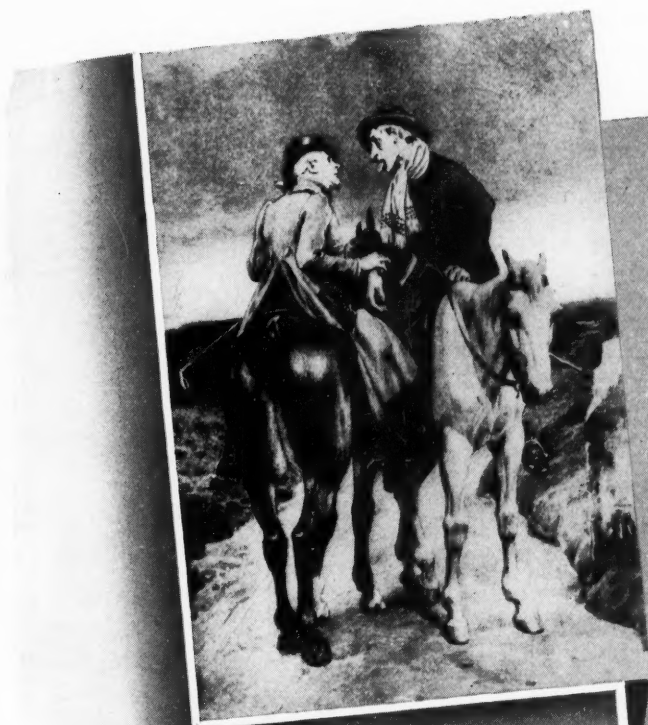
### Absorption

- Absorption, which is most rapid when the dusts are encountered, occurs almost entirely through the gastrointestinal tract and the lungs. Tetraethyl lead is absorbed through the intact skin and, because of its extreme lipoid solubility, produces an acute form of encephalitis with psychosis.

### Detoxification

- When absorbed into the blood stream, lead is first stored in glandular depots, such as the liver. From there it is mobilized and stored in the long bones along with calcium as the phosphate.

The mobilization and storage depend largely on the calcium and phosphate metabolism of the body. High calcium diet and a high serum calcium



Wayside Diagnosis

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## News in Review

### Service Plan Representatives Approve New Relationship With A.H.A. in New Orleans

The new relationship between the American Hospital Association and the hospital service associations that has been worked out by the Commission on Hospital Service and an organization committee representing the plans was presented to the midwinter conference of plans in New Orleans, February 27 to March 1, and was approved by plan representatives.

Forty-seven plans, including practically all of the large ones, were represented at the meeting. The total attendance was approximately 150 persons.

A new interim commission on hospital service was appointed to carry on the work of the former commission and the former council until the fall meeting of the A.H.A. when the amendments to the A.H.A. constitution and by-laws will be presented to the house of delegates for consideration.

The interim commission is composed of the following members: chairman, E. A. van Steenwyk, executive director, Associated Hospital Service of Philadelphia; vice chairman, John R. Mannix, director, Michigan Hospital Service; treasurer, George Putnam, president, Associated Hospital Service Corporation of Massachusetts; directors, John A. Conner, president, Central Hospital Service, Columbus, Ohio; Edward Groner, manager, Hospital Service Association of New Orleans; William S. McNary, executive director, Colorado Hospital Service Association, Denver; Sherman D. Meech, managing director, Rochester Hospital Service Corporation, Rochester, N. Y.; Mrs. Edward J. Walsh, president, Group Hospital Service, Inc., St. Louis, and Dr. Peter D. Ward, secretary, Minnesota Hospital Service Association, St. Paul.

A new directory of nonprofit hospital service plans, issued by the administrative board of the conference of hospital service plans, was made available at the New Orleans meeting. Copies have been distributed free to all hospitals that are members of plans that contribute to the research program of the conference. The directory contains full information on rates and benefits of the various plans and the payments which they make to nonmember hospitals. There is also a complete list of the member hospitals with their addresses.

At the New Orleans meeting the plans also agreed to continue their present assessment of one mill per subscriber

contract per month. This, together with the money remaining from the Julius Rosenwald grant, will be sufficient to finance the activities of the central office on their present level during the remainder of the year. There was also discussion of a national public relations program to be financed by additional contributions. Details on this proposal will be presented at the Atlantic City session in September.

### National Hospital Day Plans Are Extensive, Says Albert G. Hahn

In preparation for the observance of National Hospital Day on May 12, the National Hospital Day Committee, under the chairmanship of Albert G. Hahn, has announced extensive plans for increasing public interest in the celebration.

To this end two booklets, "Pressing Forward" and "How and Why," have been published and distributed to hospitals. The former outlines publicity procedures for radio, civic clubs and newspapers and the latter contains various suggestions for celebrating the annual event.

The Hospital Council of Albany plans to make National Hospital Day a real public relations project this year. Member hospitals are asked to invite the president and two other representatives of a group of civic organizations in Albany to tour the hospital and be guests of the institution at dinner.

Immediately following dinner, the various groups from each hospital will meet in the auditorium of St. Peter's Hospital for a short talk by Everett W. Jones of Albany Hospital, chairman of the local hospital council, on the problems of the voluntary hospital in meeting the health and welfare needs of the community. An open forum for questions and general discussion will close the day's activities.

### Physical Medicine Academy to Meet

The American Academy of Physical Medicine will hold its annual meeting and scientific session April 28 to 30 in New York, with headquarters at the Hotel Pennsylvania. Clinics will be held at the Medical Center, New York Orthopaedic Hospital, Post-Graduate Hospital and the Skin and Cancer Hospital.



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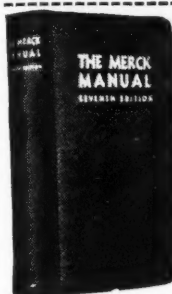
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## Says 10,000 Extra Nurses Will Be Needed This Year

"In 1941, 10,000 extra nurses will be needed and of this number 6600 will be required for military use. We also should have between 25,000 and 30,000 nurses graduating yearly between 1941 and 1946."

These statements were made by Isabel M. Stewart, chairman of the committee on educational policies and resources of the nursing council at a joint meeting of the New York Counties Registered Nurses' Association and the Great New York Hospital Association last month. Army and Navy requirements may

possibly be met from the younger graduate group, which, however, will leave a shortage in private service. This need can probably be supplied, according to Miss Stewart, from the married and retired group and perhaps by increasing student and auxiliary work and student enrollment. The greatest need is for advanced and thorough training to meet the high standards required. More money will be needed to accommodate additional nurses in schools and Miss Stewart feels that the federal government will probably have to finance the education of these extra nurses.

Administrators must be self-critical and look more deeply and intelligently

into their hospital problems, Dr. Frederick MacCurdy, president, Hospital Association of the State of New York, pointed out. He believes that nurses are being wasted on menial tasks which they should not have to do, such as messenger service and answering telephone calls. He urged that duties be delegated with more thought, leaving the nurse free to perform the tasks for which she is educated and delegating to assistants the extraneous assignments that do not require special education.

The great need for many more nurses at this time was emphasized by Alta E. Dines, chairman, National Advisory Committee on Nursing, American Red Cross. Unless this need can be filled voluntarily, Miss Dines believes that women will have to be drafted.

Schools must be expanded, Miss Dines said, graduates released from hospitals for duty and their places taken by new students or nurses who are now inactive.

A preliminary report on questionnaires sent out by the New York State Nurses' Association indicated a willingness on the part of most nurses to serve in this crisis, only a few replies indicating that they failed to grasp the seriousness of the situation. The answers received to date, according to Emily Hicks of the association, indicate that many inactive and married nurses wish to help as best they can.

## Cornell Repeats Refresher Course for Administrators

A refresher course on hospital administration will again be given at Cornell University this summer in connection with the summer school of hotel administration.

Dr. Joseph C. Doane, medical director of Jewish Hospital, Philadelphia, and chairman of the editorial board, *The Modern Hospital*, will be in charge. He will be assisted by Dr. Donald Smelzer, who on June 1 will become director of Germantown Hospital and Dispensary, Philadelphia.

The two weeks' course will be given beginning July 14. Tuition is \$24 and board and room will amount to \$12 or \$15 a week.

## Two Laundries Damaged by Fire

Laundries at two hospitals were damaged by fire last month on the same night, March 10. Several thousand dollars of damage was done to the laundry building of the Central Islip State Hospital at Central Islip, Long Island, by a blaze which firemen fought for nearly two hours. Damage estimated at \$40,000 was done to the New Jersey State Hospital laundry at Trenton. In each instance there was no danger to patients.



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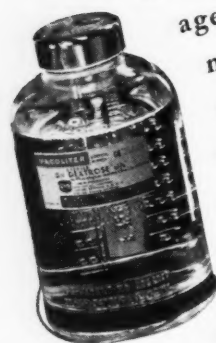


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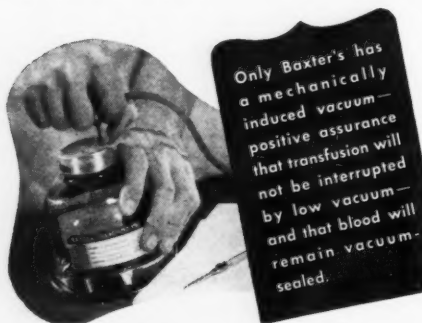
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## Texas Association Argues Licensing Law at Successful Annual Meeting

With a registration of 1056 the Texas Hospital Association held its most successful meeting, February 27 to March 1, at Dallas. The medical record librarians, occupational therapists, physical therapists and nurse anesthetists joined in the meeting.

The most significant action was consideration of a hospital licensing law which had been prepared by the association and introduced into the state legislature. There was some opposition to the proposed bill from certain of the smaller physician-owned hospitals but most of those present seemed to be strongly in favor of it. Under the bill the state department of health and the state board of health (which, in Texas, are two separate bodies) will control the issuance of licenses and the inspection of hospitals. A committee was appointed to iron out all controversial details.

Dr. Bert W. Caldwell, executive secretary of the A.H.A., spoke strongly in favor of a licensing act, declaring that without it any kind of an institution could call itself a hospital. He pointed out that there are more than 2000 "hospitals" that are not registered by the American Medical Association and that the existence of these institutions, most of which are of low grade, serves to injure the whole field.

The importance of setting up a salary scale for employes was one of the many points on personnel management presented by Nellie Gorgas, assistant to the director of the University of Chicago Clinics. A proper salary schedule will decrease turnover and improve personnel relations as well as help in budgeting hospital expenses, Miss Gorgas stated.

Miss Gorgas pointed out that the trustees of the hospital must decide certain basic policies before a salary schedule can be adopted. For example, they might state: (1) we want to set up a fair and equitable salary schedule and keep it currently up to date; (2) we will base our schedule on salaries paid in other local institutions for the same work or will adopt a schedule lower by a certain percentage than other institutions pay; (3) we will base our salaries on the employe's contribution to the institution and not on his academic preparation or unused abilities; (4) our minimum salary will be based on the lowest amount that is consistent with health and decency.

A strong plea for uniform accounting was made by Mrs. Ruth Rogers, accountant, Memorial Hospital, Houston.

A high spot of the program was the announcement by Gerhard Hartman, executive secretary of the American College of Hospital Administrators, that a

hospital institute would be held in Texas sometime after November 1941 under the sponsorship of the college, the Texas Hospital Association and the local educational institutions. Arrangements were made to have Baylor University and Southern Methodist University and the Dallas Hospital Council join in the sponsorship.

An enrollment of more than 87,000 persons in Group Hospital Service, Inc. of Texas was announced by J. F. Kimball, the administrator. Although the state-wide plan is only 18 months old, it has 233 hospital members.

A serious crisis for hospitals was predicted by Father Alphonse M. Schwitalla, president of the Catholic Hospital Association. Problems facing hospitals, he said, include: (1) cooperation in physical examinations by local selective service committees; (2) rehabilitation of persons rejected by draft boards; (3) maintenance of medical, nursing and other personnel; (4) care for civilian population during crises; (5) defense of educational standards of physicians, nurses, technicians and others, and (6) preparation for inflation and social revolution.

New officers of the association are: president, Harry G. Hatch, Northwest Texas Hospital, Amarillo; president elect, Dr. E. M. Dunstan, Parkland Hospital, Dallas; vice presidents, Sister Antonia, St. Paul's Hospital, Dallas; George Buis, Brackenridge Hospital, Austin, and John C. Crimen, Southwestern General Hospital, El Paso; treasurer, Eva Wallace, All Saints Hospital, Fort Worth. The executive secretary of the Texas Hospital Association is Madelyne Sturdavant of the Methodist Hospital, Dallas.

## Minnesota Issues Standards for All Maternity Hospitals

New standards for the operation of maternity hospitals in Minnesota were issued last month by the medical unit of the division of social welfare of the state department of social security.

The standards require a license for the operation of a maternity hospital and provide penalties for failure to comply. They are divided into the following sections: location, building, maternity department, personnel, practices, reports and records, social aspects. A separate section is provided to govern institutions for unmarried mothers.

There are also rules for visitors to maternity departments of hospitals limiting them to two, exclusive of the husband, at any one time and otherwise controlling their behavior.

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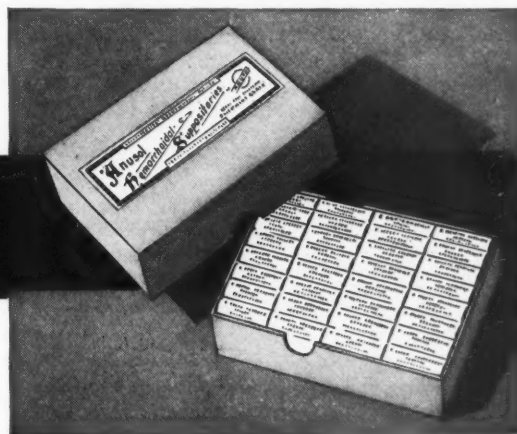


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## Bed Capacity Increases by 31,219 During Past Year, A. M. A. Reports

Beds in hospitals registered by the American Medical Association increased from 1,195,026 at the end of 1939 to 1,226,245 at the end of 1940, or an increase of 31,219 beds during the year. The number of registered hospitals, however, increased only from 6226 to 6291, a gain of 65 institutions.

A total of 10,087,548 patients was admitted during the year, which is a gain of 208,304. Average daily occupancy in all hospitals increased from

996,483 to 1,026,171. Thus there were nearly 30,000 additional patients in hospitals each day to occupy the 31,000 additional beds available.

The average occupancy, as computed by the American Medical Association, was 83.7 per cent in all hospitals and 70.3 per cent in general hospitals. These are the highest occupancies ever reported by the A.M.A.

The governmental hospitals were credited with an occupancy of 89.8 per cent, the nonprofit hospitals, with 70.6 per cent and the proprietary hospitals, with 56.8 per cent. The association computes occupancy percentages on the basis

of the bed capacity at the end of the year, disregarding the gain in bed capacity during the twelve months. Thus the reported figure is slightly lower than the true situation.

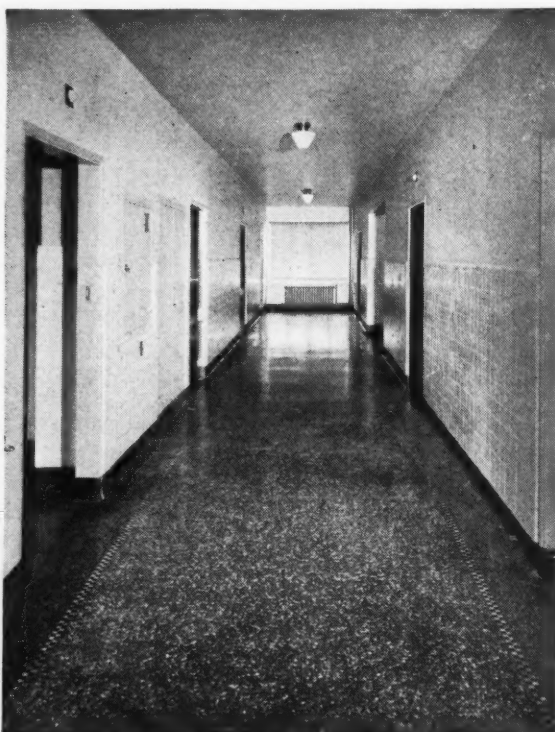
Of the net gain of 65 hospitals during the year, 27 are governmental and 38 are nongovernmental. The former increased in bed capacity by 28,543 beds and the latter, by 2676 beds.

In patients admitted, the governmental hospitals increased from 2,734,375 in 1939 to 2,869,004 in 1940 while the nongovernmental hospitals admitted 7,144,869 in 1939 and 7,218,544 in 1940.

The average size of all hospitals in the United States has increased from 125 beds in 1927 to 195 beds in 1940. In acute disease hospitals (excluding those for tuberculous and mental cases) the average size in 1927 was 73 beds and in 1940 it was 107 beds. Thus, in each category the average size of hospital has increased approximately 50 per cent in these thirteen years.



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## New York Catholics Will Enlarge Hospital Facilities

The division of health of the Catholic Charities of New York will spend more than \$2,000,000 this year to extend the facilities of the 26 general and special hospitals affiliated with the charities, the Rev. John J. Bingham, director of the division, said in his annual report published last month.

The report said that last year the hospitals cared for 67,458 patients and the clinics maintained by eight of the hospitals treated 228,631 patients and gave 24,000 free prescriptions to persons who could not pay for them. Speaking of the need for additional building, Father Bingham said:

"Our hospitals that care for chronic cases, for instance, are 100 per cent occupied and have long waiting lists. For the care of the mentally sick we must rely almost entirely on the services provided by the extensive facilities of the state."

The twenty-second annual appeal of the charities in the 374 parishes of the archdiocese began on March 23.

### Sisters Care for Chronically Ill

St. Joseph Home, Quincy, Ill., has changed its name to St. Joseph Hospital for the Chronically Ill. The Sisters of the Poor of St. Francis opened the home about 15 years ago as a home for working girls. A year ago, however, when St. Mary Hospital became overcrowded, the Sisters converted the home into a hospital for the chronically ill. The new hospital is nonsectarian and is available to persons of any age who are chronically ill and to patients who have been discharged from acute disease hospitals.

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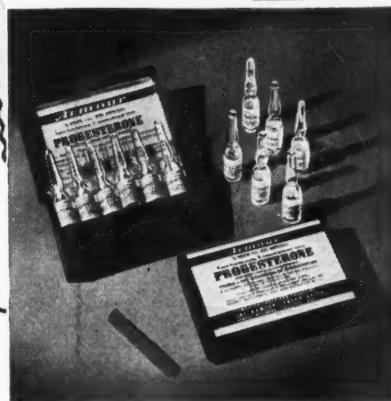
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## Defense Problems Paramount in Minds of New England Assembly Delegates

Hospital people of New England are thinking in terms of national defense and the existing world crisis. There was hardly a session of the nineteenth annual meeting of the New England Assembly that did not present some problem attendant upon cooperation in working out the medical procedure involved in the Selective Service Act, in establishing hospitals as training centers and in preparing for civil emergencies caused by sabotage, bombings in the event of actual war and epidemics.

In many communities definite plans already have been formulated in which hospitals, local medical societies, chapters of the Red Cross and various public health and civic organizations are pooling available resources. Other communities were urged to readjust their mental attitudes and to assume that the worst is going to happen. A resolution adopted by the assembly urged its trustees to "interest themselves in developing emergency facilities in their respective hospitals in keeping with the national defense preparedness program."

Dr. Frederic A. Washburn, director emeritus of the Massachusetts General Hospital, suggested the addition of small

annexes providing facilities for 40 or 50 beds and also, in emergencies, emptying the hospitals of people that do not need to be there. The shortage of nurses, already a serious problem, must be met, if necessary, by shortening present training courses, possibly giving the students their practical experience in military hospitals, Doctor Washburn thinks.

"Sit down now with local medical societies and see what men can best be spared" was the suggestion of James A. Hamilton, director, New Haven Hospital, New Haven, Conn.

A warning against disrupting normal hospital internships and residencies was issued by Dr. Nathaniel W. Faxon, director, Massachusetts General Hospital, Boston, in a paper read by Dr. Norman C. Baker. The defense program would be defeated, in part, by draining hospital personnel, he pointed out, particularly those concerned with teaching.

"There should be the closest cooperation possible between large and small hospitals in the preparedness program," according to Helen Goodwin, superintendent, Rumford Community Hospital, Rumford, Me. She stressed the importance of working with local draft boards

to make sure that medical staffs, laboratory technicians and other personnel are not depleted by needless enlistment.

Second only in importance to the present war situation in the minds of the New England group is the question of trusteeship. In addition to an evening trustee section, practically every session of the convention included something pertaining to the functions of these lay groups. Dr. Charles F. Wilinsky, in his presidential address (read for him since illness prevented his attendance), appealed to the trustees "for their sympathetic consideration of their hospital administrators, to give them moral encouragement, loyal support and appreciation which will inspire them to renewed effort." John MacGregor, trustee, Faulkner Hospital, Jamaica Plain, traced briefly the story of hospitals and presented figures showing the tremendous growth of hospitals and the large sums represented in their operation and maintenance.

"The future of maintaining and stabilizing our voluntary hospital system," said Samuel Stewart, president, Central Maine General Hospital, Lewiston, "depends upon the attitude, interest and participation of the trustees in all matters affecting the care of the sick as well as in matters of a general nature. There

(Continued on page 116)

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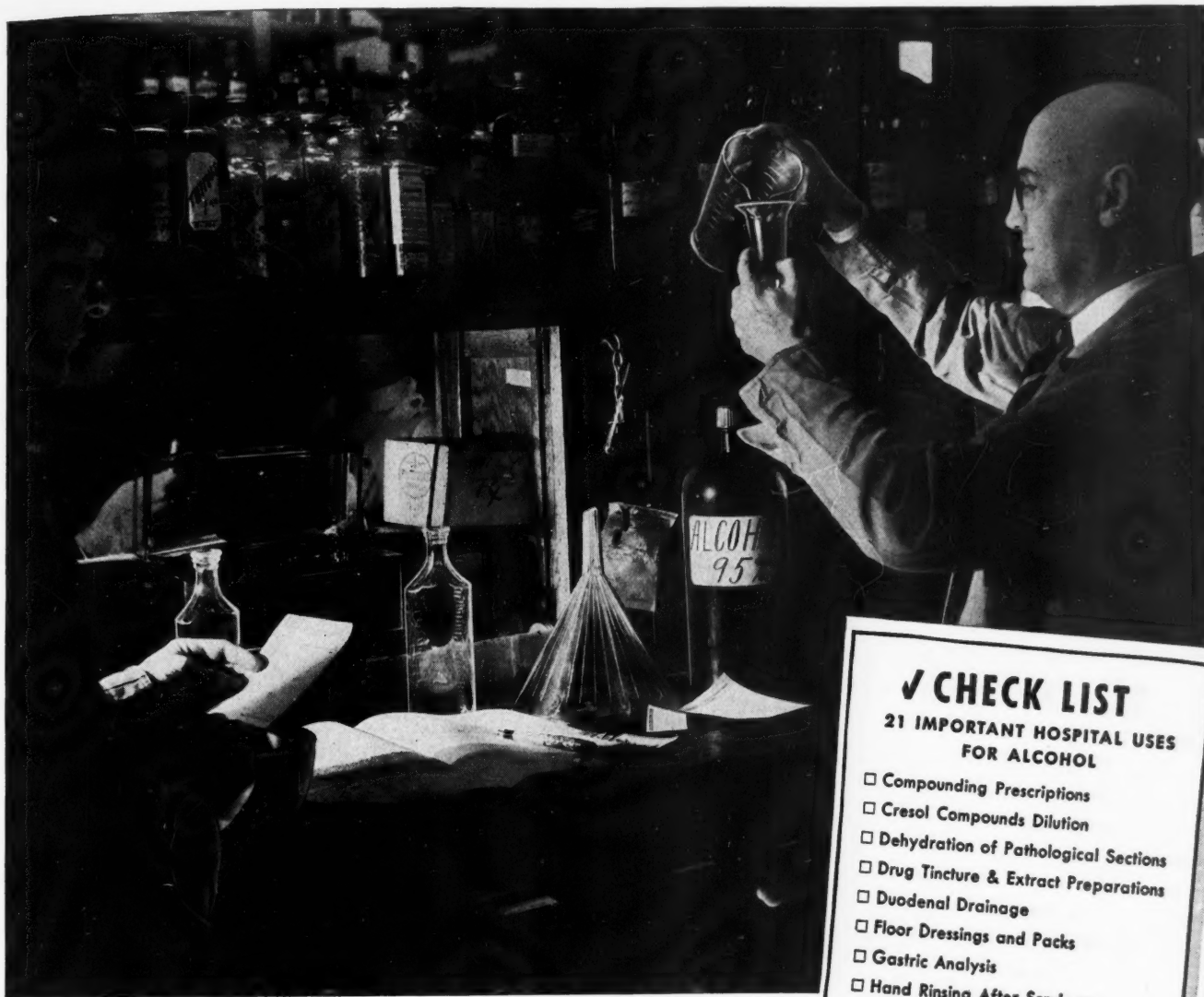
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Because the quality of medical gases cannot be determined except by accurate chemical analysis and these products are purchased and used sight unseen, CONFIDENCE must be placed in the Manufacturer. Back of the "Puritan Maid" label on every cylinder, identifying the products of the Puritan Compressed Gas

Corporation, is a reputation earned through many years of service to the Profession, during which time we have grown to be one of the largest producers of these products in the world.

This unit has had widespread acceptance and is known for effective and economical administration of therapeutic gases. Write for Illustrated Booklet "Puritan Gas Therapy Equipment."

In compounding of medicines, tonics, and salves, 95% Pure Ethyl Alcohol is widely used in the hospital pharmacy for serving patients in the hospital as well as the clinic.



## Because U.S.I. Pure Alcohol Exceeds U.S.P. Standards, It Is Better Suited For PHARMACEUTICAL PREPARATIONS

THE highest degree of alcohol purity is essential in the compounding of pharmaceutical preparations—in medicines, tonics, and salves. Leading hospitals prefer U.S.I. Pure Alcohol for compounding pharmaceuticals—and for every other application—because its purity is safeguarded by rigid testing and control methods.

U.S.I. Pure Alcohol is tested not only by the standards of U.S.P. XI and N.F. VI—but also by additional testing procedures that U.S.I. has evolved out of its long experience in the manufacture of pure alcohol. This extra care in testing is your assurance of alcohol that meets your most exacting requirements.

Specify U.S.I. Pure Alcohol for pharmacy, laboratory, or operating room use. The U.S.I. representative will be glad to assist you in alcohol selection.

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#### 21 IMPORTANT HOSPITAL USES FOR ALCOHOL

- ☐ Compounding Prescriptions
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- ☐ Sutures Sterile Solution
- ☐ Therapeutic Nerve Block





## Defense Problems Paramount With New England Assembly (Continued from page 114)

is great need for further enlightenment among trustees," he added.

Interspersed with these trustee sections was a round table conducted by Raymond P. Sloan, editor of *The MODERN HOSPITAL*, and trustee of Long Island College of Medicine.

The necessity for continuing education for physicians, nurses, hospital administrators as well as trustees was urged by various speakers, including Dr. Frederick T. Hill, president of staff, Thayer Hospital, Waterville, Me.; Dr. Reginald Fitz, assistant to the dean, Harvard Medical School; Martha Ruth Smith, director of division of nursing education, Boston University, and Dr. Arthur C. Bachmeyer, president, A.C.H.A.

Leonard Ware, editorial writer, *Boston Herald*, suggested (1) that an authorized executive be on duty at all times to speak for the hospital on questions arising from spot news; (2) that institutional publicity discuss how to get medical care for less money or some equally interesting and tangible phase of the hospital's work, and (3) that medical information centers be established for the convenience of the press and the education of the public.

Some helpful rules for purchasing and inventory control in the small hospital were submitted by Pearl R. Fisher, Thayer Hospital, Waterville, Me., in which the superintendent acts as purchasing agent. "Buying from a small number of reliable firms ensures prompt and satisfactory service. Establishing good credit reputation and taking cash discounts are decidedly advantageous. The hospital journals and even the daily newspaper are aids to scientific purchasing. Careful supervision and handling of supplies are necessary. Standards should be maintained for each department. A modified perpetual inventory in addition to a complete annual inventory seems best suited for the smaller hospital," Miss Fisher declared.

Officers of the assembly for the coming year are as follows: president, Dr. Joelle C. Hiebert, Central Maine General Hospital, Lewiston; vice president, Dr. Wilmar M. Allan, Hartford Hospital, Hartford, Conn.; treasurer, Donald S. Smith, Mary Hitchcock Memorial Hospital, Hanover, N. H.; secretary, Dr. A. G. Engelbach, Cambridge Hospital, Cambridge, Mass. Trustees elected are Lawrence C. Campbell, Barre City Hospital, Barre, Vt.; Dr. Stephen S. Brown, Maine General Hospital, Portland, and Sister Flore, Notre Dame Hospital, Nashua, N. H.

## Bill to Amend Security Act Would Cover Hospital Employees

Senator David I. Walsh of Massachusetts has introduced into the United States Senate a bill to amend the Social Security Act so that hospital employees would be covered by the old age provisions of the act. It would not provide unemployment insurance.

In introducing the measure, Senator Walsh stated: "This bill would safeguard the tax-exempt status of the religious and charitable agency paying the tax by requiring that all revenues collected from such tax-exempt agencies 'shall be paid directly into the federal old-age and survivors' trust fund.' In this way the proposed amendment would, in reality, convert what otherwise would be a general tax into a true contribution to a trust fund, available only for the payment of old-age benefits, and not subject to appropriation by Congress for any other purpose."

## Hospital Sunday Breaks Record

With collections already past the \$15,000 mark and more reports still coming in, Evanston Hospital, Evanston, Ill., celebrated the most productive Hospital Sunday in the history of the institution. In 1935 the collections were less than \$6000, and last year, less than \$14,000.

# Presbyterian Hospital saves \$300 a month with REFINITE soft water!

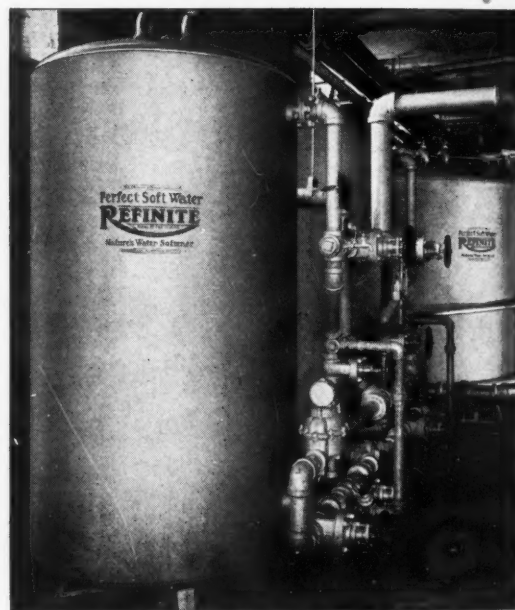
• In six months of operation with REFINITE Soft Water, Presbyterian Hospital, Chicago, saved \$1,841. The saving on laundry supplies alone was close to \$900 in the first six months. Housekeeping supplies were down almost 50%. Boiler compounds and acids for cleaning boiler tubes were eliminated entirely. Almost three-fourths of the soap used in dishwashers was saved. Scale was eliminated from sterilizers and water heaters.

This is the REFINITE record on water with only 8 grains of hardness per gallon. Think of the savings where water is 15 or 20 grains! No hospital need be without Soft Water. Write for details of Refinite's SELF-LIQUIDATING PURCHASE PLAN. Monthly payments governed strictly by the amount YOU SAVE. Write today!

THE **REFINITE** CORP.  
RIVAL OF THE CLOUDS

REFINITE BLDG.

OMAHA, NEBR.



The REFINITE Softener in Presbyterian Hospital, Chicago

### LAUNDRY SUPPLY COSTS (6 Months)

	Hard Water	Soft Water
Tallow .....	\$ 625.04	\$ 49.25
Caustic .....	85.26	26.78
Silicate .....	53.03	8.66
Soda .....	307.97	68.64
Bleach .....	193.23	160.16
Blanket Soap .....	150.00	52.51
Experimental Soap .....		157.50

TOTAL .....\$1,414.53 \$523.64

### HOUSEKEEPING SUPPLY COSTS (6 Months)

Scouring Powder.....	\$165.00	\$ 82.50
Soap Powder.....	270.00	225.00
Sal Soda.....	112.45	63.00
Dishwashing Powder.....	335.15	148.28

TOTAL .....\$882.60 \$518.78

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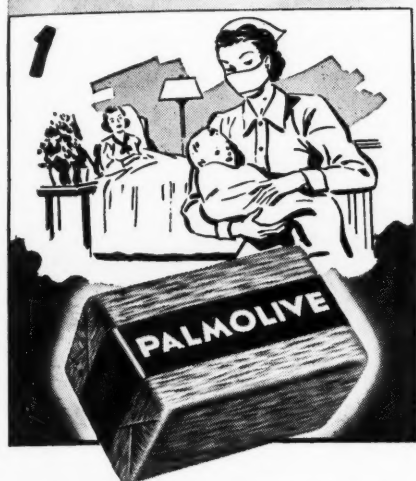
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SPITAL



WHAT DO  
THESE 3 SOAPS  
HAVE TO DO  
WITH MODERN  
HOSPITAL  
THERAPY?



**Patients like Palmolive**, the world's favorite toilet soap. Chances are, they use this same fragrant soap at home. It adds to their comfort . . . helps them feel less "strange." Made with Olive and Palm Oils, Palmolive costs no more than many less favored brands.



And there's something satisfying about Colgate's famous Floating Soap. It is fragrant, gentle to the skin, and it gives abundant lather in either hot or cold water. Colgate's Floating is a top-quality, economical soap . . . another "nice touch" that patients will appreciate.



**Women like Cashmere Bouquet's** rich, creamy lather . . . its delicate perfume. It leaves them feeling dainty long after use. It's a luxurious touch that helps make a hospital more pleasant. An extra advantage—Cashmere Bouquet is hard-milled . . . economical to use.



A HINT TO  
SUPERINTENDENTS  
— FROM THE  
EXPERIENCE OF A  
GROWING NUMBER  
OF HOSPITALS

There can be more to helping a patient get well than medicine . . . than even brilliant surgery and sound medical care. These are the "small things" that put a patient at ease. The quality of the cooking . . . the manners of the nurses . . . the decoration of the rooms. Even the luxurious touch that comes from fine, fragrant soaps has its place in modern therapy. Why not let your patients enjoy gentle Palmolive? The delicate perfume of Cashmere Bouquet! The abundant lather of Colgate's Floating Soap! These brands are priced to fit your budget. Ask your C.P.P. man for costs on the sizes you need. Or, write to us direct.

**COLGATE-PALMOLIVE-PEET CO.**  
INDUSTRIAL DEPARTMENT, JERSEY CITY, N. J.



## Massachusetts Group Reelects Oliver G. Pratt as President

Oliver G. Pratt, superintendent, Salem Hospital, Salem, Mass., was reelected president of the Massachusetts Hospital Association at its annual meeting. At the same time Warren F. Cook, superintendent, New England Deaconess Hospital, Boston, was reelected treasurer. Other officers are: vice president, Mary R. MacQuinn, Benjamin Stickney Cable Memorial Hospital, Ipswich; secretary, Dr. W. Franklin Wood, McLean Hospital, Waverley, and trustee, Rev. Father Donald McGowan, St. Elizabeth's Hospital, Boston.

In his annual report Mr. Pratt made the following suggestions for activities for next year: (1) a study of old age pension plans so that a model plan might be developed for the benefit of our individual member hospitals; (2) a study of the value of district conferences, the districts perhaps determined by the geographical boundaries of the district associations of the state nurses' association and perhaps having the voting members of Blue Cross as representatives from these districts; (3) the continuing expansion of the Massachusetts Hospital Association to the end that the administrator of every mental and tuberculosis hospital will feel it essential to be a

member; (4) the development of a state-wide educational program making possible courses for various types of hospital employees, taking advantage of the extension courses provided by the state department of education as well as the facilities of the educational institutions of the commonwealth, particularly the state college.

## Work to Start on Detroit's \$100,000,000 Medical Center

A \$100,000,000 city medical center, with extensive hospital facilities for the exclusive use of indigent patients, will begin to take shape in Detroit when projected construction work is started this spring.

First of several individual units to be constructed will be a hospital and medical science building sponsored by Wayne University College of Medicine. Laboratory buildings, an out-patient department, women's and children's medical centers, a nurses' training school and dormitories will be added later.

The plant is to be located on a campus overlooking the Detroit River on the side of Detroit's old Memorial Park. A fund of more than \$8,000,000 has already been accumulated. Most of the financing is expected to come from non-governmental sources.

## Occupational Therapists Stage Play

A feature of the program of the New England Hospital Assembly in Boston was a dramatization presented by the Massachusetts Association for Occupational Therapy entitled "Occupational Therapy Pays Its Way." The story, cleverly written and acted, was told in a prologue and five scenes. Prominent in the cast were Frances E. Wood, McLean Hospital, Waverley, Mass.; Dr. Roy D. Halloran, superintendent, Metropolitan State Hospital, Waltham; Dr. Russell E. Leach, also of the Metropolitan State Hospital, and Marie Murphy, Faulkner Hospital, Jamaica Plain.

## Eastern N.E.H.A. Chapters Convene

The first district meeting of the National Executive Housekeepers Association was held in Atlantic City, N. J., February 14 and 15, for the purpose of completing the organization of the eastern district. Officers elected at the meeting are: governor, Thelma Nowell, executive housekeeper, Hotel St. James, Philadelphia; vice governor, Mrs. June Malone, executive housekeeper, General Hospital, Lancaster, Pa., and secretary-treasurer, Mrs. Agnes Carpenter, Washington, D. C. Mrs. Doris L. Dungan, national president of the association, presided over the sessions.

## Better sleep

FOR MANY

## allergics

supremely comfortable mattresses and pillows  
made without the ordinary materials  
to which some individuals are allergic



*Molded of pure foamed latex...* odorless, dustless, lintless, hairless, featherless. Koyalon mattresses have not only contributed to the relief of certain allergies. They have proven their superiority from the standpoint of pure restfulness—in hospitals and thousands of homes throughout the country. More economical, too—Koyalon substitutes for metal parts and loose padding a single unit that holds its shape and resiliency for years.



## More restful

Note how perfectly Koyalon shapes itself to the body. It supports evenly, completely. Buoyant—alive with the resiliency of millions of microscopic latex "springs." Yet it never flattens muscles tiresomely, because it's softer than a baby's flesh.

**IT BREATHES.** Not to be confused with ordinary sponge or rubber products, this odorless material is penetrated by millions of connecting pores. These provide hygienic self-ventilation—and permit easy and thorough sterilization.



# Koyalon

THE NEW IDENTIFYING MARK OF U. S. ROYAL FOAM  
MATTRESSES • PILLOWS • HOSPITAL CUSHIONS

UNITED STATES RUBBER COMPANY



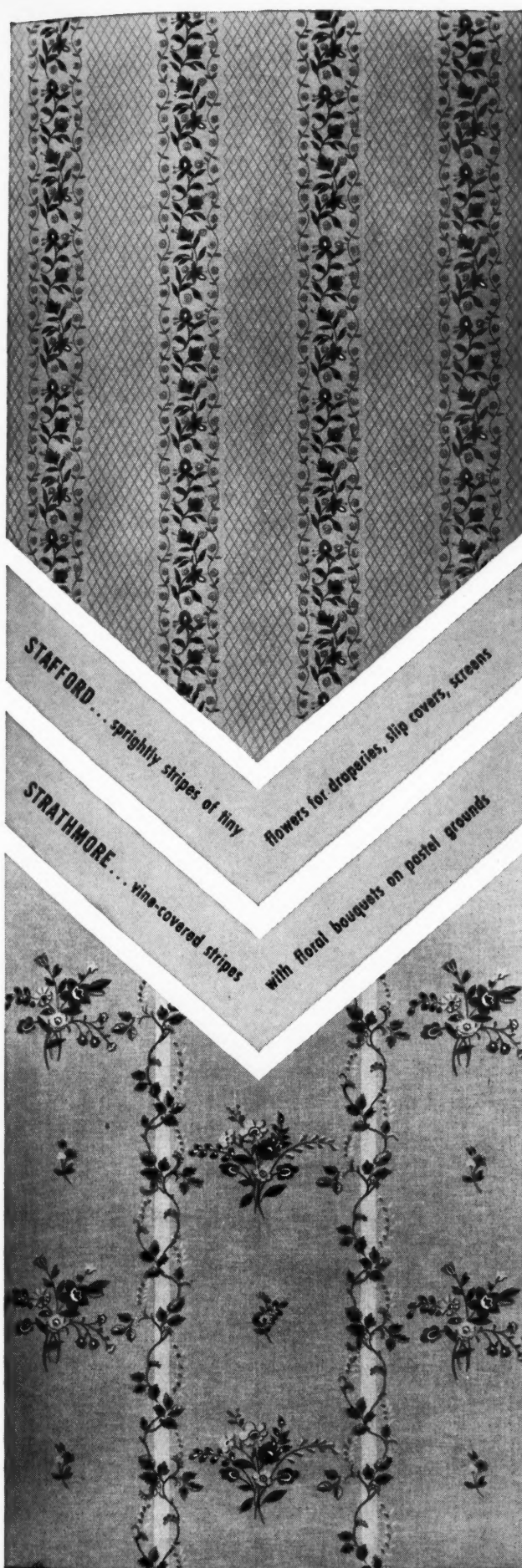
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# SERVICE STRIPES

ON FAMOUS-FOR-WEAR  
WOVEN-WITH-MOHAIRS

Over a quarter of a century of service in American hospitals should win Goodall fabrics a row of honor stripes ...and has, in the minds of hundreds of executives! They depend on these famous woven-with-mohair fabrics to keep rooms bright and clean, budget expenses down.

Hospital executives first specified these weaves as *Leshner Mohairs*, later as *Sanvale Fabrics*; now, named for the Goodall looms that produced them all, they come to you with a new speed-record. Your decorator or contractor orders direct from the mill through our new showrooms—with no red tape, no go-betweens. We invite you to visit us ... or send for samples of new Goodall weaves for bedspreads, slip covers, furniture, draperies or screens.

# GOODALL DECORATIVE FABRICS

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DRAPERIES • UPHOLSTERIES • CASEMENTS • SLIP COVERS • BEDSPREADS



## Standard Colors Identify Anesthetic Gas Cylinders

A revised simplified practice recommendation on color marking for anesthetic gas cylinders has been sent out by the National Bureau of Standards to anesthetists, the American Hospital Association and manufacturers, distributors and others interested in anesthetic gases. Under the new simplified practice the following identifying colors are suggested:

Oxygen	green
Carbon dioxide	gray
Nitrous oxide	light blue
Cyclopropane	orange
Helium	brown
Ethylene	red
Carbon dioxide and oxygen	
	gray and green
Helium and oxygen	
	brown and green

## Blood Plasma Service Given England at Extremely Low Cost

A detailed report on the operation of the blood plasma service which provided blood plasma to England was issued last month by the Blood Transfusion Association of New York City. The service was operated by the association, the American Red Cross and nine leading voluntary hospitals of New York City

April 3-4—Kentucky Hospital Association, Brown Hotel, Louisville.  
April 7—Tennessee Hospital Association, Nashville.  
April 10-11—Arkansas Hospital Association, Pines Hotel, Pine Bluff.  
April 16—Louisiana Hospital Association, New Orleans.  
April 16-18—Hospital Association of Pennsylvania, Bellevue-Stratford Hotel, Philadelphia.  
April 17-19—Southeastern Hospital Conference, Jung Hotel, New Orleans.  
April 21-23—Iowa State Hospital Association, Fort Des Moines Hotel, Des Moines.  
April 24-25—Mid-West Hospital Association, President Hotel, Kansas City.  
April 24-26—Carolinas-Virginias Hospital Association, Greenville, S. C.  
April 25-26—Washington State Hospital Association, Tacoma.  
April 29-May 1—Ohio Hospital Association, Deshler-Wallick Hotel, Columbus.  
May 7-9—Tri-State Hospital Assembly, Stevens Hotel, Chicago.  
May 12—Mississippi State Hospital Association, Biloxi.  
May 15-17—New Jersey Hospital Association, Atlantic City.  
May 21-22—Connecticut Hospital Association, Bridgeport, Conn.  
May 22-23—Minnesota Hospital Association, Lowry Hotel, St. Paul.  
May 21-23—Hospital Association of the State of New York, New York City.  
June 16-20—Catholic Hospital Association, Convention Hall, Philadelphia.

## Coming Meetings

June 23-27—Canadian Medical Association, Royal Alexandra, Winnipeg, Man.  
July 2-3—Hospital Association of Nova Scotia and Prince Edward Island, Hotel Nova Scotian.  
July 2-3—Hospital Association of New Brunswick, Hotel Nova Scotian.  
July 17-18—Mid-West Institute for Hospital Administrators, University of Colorado School of Medicine and Hospitals, Denver.  
Aug. 17-19—National Hospital Association, Chicago.  
Sept. 12-14—American Protestant Hospital Association, Atlantic City, N. J.  
Sept. 13-15—American College of Hospital Administrators, Atlantic City, N. J.  
Sept. 15-19—American Hospital Association, Atlantic City, N. J.  
Oct. 8-10—Ontario Hospital Association, Royal York, Toronto.  
Oct. 14-17—American Public Health Association, Hotel Traymore, Atlantic City, N. J.  
Oct. 23-24—Missouri Hospital Association, St. Louis.  
Oct. 24—Idaho Hospital Association, St. Joseph's Hospital, Lewiston.  
Oct.—Saskatchewan Hospital Association, Moose Jaw, Sask.  
Oct.—British Columbia Hospital Association, Empress Hotel, Victoria.  
Nov. 13-14—Kansas Hospital Association, Topeka.  
Nov. 13-14—Oklahoma Hospital Association, Oklahoma City.  
Dec. 4—Utah Hospital Association, Salt Lake City.  
Jan. 1942—Wisconsin Hospital Association, Hotel Schroeder, Milwaukee.  
Feb. 26-28—Texas Hospital Association, Houston.

from August to early this year when the service was discontinued because the British were able to supply their own needs.

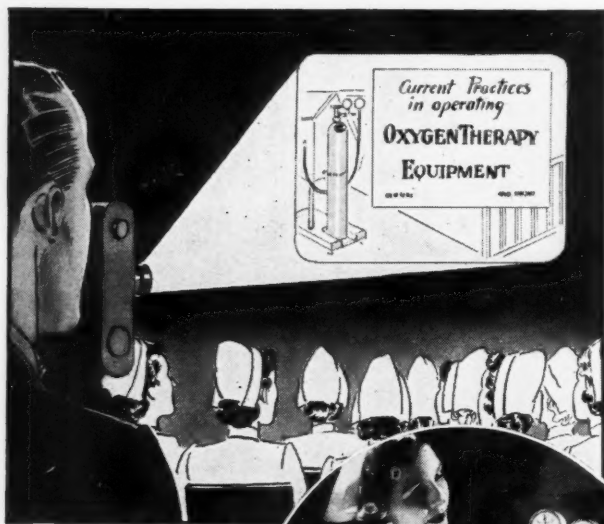
Cooperating hospitals were Presbyterian, Mount Sinai, New York, Long Island College, Memorial, New York Post-Graduate, Lenox Hill, Hospital for

Joint Diseases and Jewish Hospital.

Because the blood was donated and many of the services also, the cost was very low. Plasma valued at approximately \$400,000 was furnished at a cost of about \$40,500, or a cost per liter, without saline, of about \$14.70, including all capital charges.

# HOW LINDE CAN HELP YOU HOLD DOWN


## oxygen therapy costs



Ask for a copy of Linde's "Handbook," or a showing of the Linde motion picture on the accepted practices in handling commonly used types of oxygen therapy apparatus and equipment.

FOR many years, the Linde organization has specialized in the manufacture and handling of oxygen which meets the purity requirements of the United States Pharmacopoeia. Likewise it has co-operated with leading hospitals, physicians, and manufacturers of equipment in studying the mechanical problems of oxygen therapy.

As a result of this practical experience, Linde is able to extend to hospitals technical advice and assistance which helps them use Linde Oxygen, U.S.P. most effectively. For detailed information on how Linde might help your hospital, write us.

**THE LINDE AIR PRODUCTS COMPANY**  
Unit of Union Carbide and Carbon Corporation  
Offices in New York  and Principal Cities

## LINDE OXYGEN U. S. P.

The word "Linde" is a trade-mark of The Linde Air Products Company



## .. A Hypodermic for a TIRED OLD HORSE

"QUALITY" is definitely a work-weary word . . . a tired old horse that has been sadly misused and abused by purveyors of merchandise in all fields. Today it needs the hypodermic of "truth" to revive lost powers; to put force into a basically sound constitution.

We have our own method for rating quality as applied to hospital supplies and equipment. Rigid pre-testing for physical fitness and special suitability for Hospital Service automatically weeds out merchandise that doesn't measure up to Will Ross quality standards.

Sometimes it takes a program of ruthless abuse of the product to find out just how far quality goes. Sometimes a manufacturer's specifications are torn to pieces and a new set supplied by us before we are satisfied that his merchandise can support the *Will Ross unconditional guarantee*. In all cases, you can be sure of Will Ross "quality". We have great respect for the true worth of the word and use it only when we know it can safely carry the load put upon it.



# Will Ross, INC.

*Quality Hospital Supplies*

3100 W. CENTER STREET

MILWAUKEE, WIS.



## Hospital Men Are Advisers on Exhibits at Museum of Health

Six hospital administrators will serve on the newly created scientific advisory board of the American Museum of Health. They are Dr. Willard C. Rappleye, New York City commissioner of hospitals; Dr. Karl M. Bowman, director of the psychiatric division of Bellevue Hospital; Dr. S. S. Goldwater, president of the Associated Hospital Service of New York; Dr. C. W. Munger, director of St. Luke's Hospital; Dr. C. P. Rhoads, director of Memorial Hospital for the Treatment of Cancer and Allied Diseases, and Dr. Thomas M. Rivers, director of the Hospital of the Rockefeller Institute for Medical Research. Dr. Haven Emerson, former health commissioner of New York City, has been named chairman.

Comprising 77 leaders in health and medicine, the board has been formed to "assure the continuing scientific integrity of the exhibits in the museum."

## To Offer Occupational Therapy

Beginning next September Columbia University will offer a three year course in occupational therapy, upon instigation of the hospital occupation committee of the New York City Visiting Committee. At present there are only five schools throughout the country.

## New A.C.H.A. Directory Out

A revised and substantially enlarged directory of the American College of Hospital Administrators was issued last month. The new directory lists biographic material about 917 fellows and members. There are 27 honorary fellows, 334 fellows, 395 members and 161 associate members. Copies have been distributed to all those listed in the book and to the secretaries of all state hospital associations. The new directory follows the general pattern of the earlier directory issued in 1938 except that the list of publications has been omitted and the names are grouped according to classification of membership. There are also geographical and alphabetical indexes.

## New York to Build Cancer Hospital

At an estimated cost of \$2,650,000 a new 315 bed cancer hospital and clinic, to be known as Nightingale Hospital, will be constructed by the City of New York. The site for the new hospital has been donated by Columbia University and Presbyterian Hospital. The need for the hospital was projected by Dr. S. S. Goldwater, former commissioner of hospitals, and its authorization represents a major accomplishment on the part of his successor, Dr. Willard C. Rappleye.

## Commonwealth Fund Hospital at Kingsport, Tenn., Enlarged

Additions at both ends of the Holston Valley Community Hospital at Kingsport, Tenn., are now being built, according to an announcement from the Commonwealth Fund. They will provide space for 39 additional beds and eight bassinets, raising the total capacity of the hospital to 109, which in emergency can be increased to 117.

When the new beds are available, changes in the group hospitalization plan will go into effect. These substitute a single contract providing protection for a subscriber and his family for the arrangement that formerly prevailed. For \$1.50 a month, a subscriber and his "principal dependent" will receive full benefits; other dependents may receive equivalent care at the flat rate of \$1 per day.

## Group Insurance Proposed by Laborites

The Chicago Federation of Labor has decided to set up a group hospitalization program of its own, according to an announcement in *Federation News* of March 15. The Union Hospital Association Plan is incorporated under the laws of Illinois, the report states, as a nonprofit corporation operated as a pure assessment plan.



### THE HOSPITAL BUYER can SERVE TWO MASTERS!

**I**N surgical blades, the insistent requirements of the most exacting surgeon need not conflict with budget limitations. **Crescent blades are sharper, more rigid, and better balanced**—by virtue of their longer beveled cutting edge on a heavier body, in which one-third more steel is evenly distributed without thinning down from the back.

**Crescent blades are more economical**—depending on the quantity ordered, they cost up to 30 per cent less.

Your surgical staff and your board of management will both join in approving the specification of Crescent blades, which readily fit all standard handles. Call your surgical dealer...or write to

CRESCENT SURGICAL SALES CO., Inc., New York

## CRESCENT SURGICAL BLADES



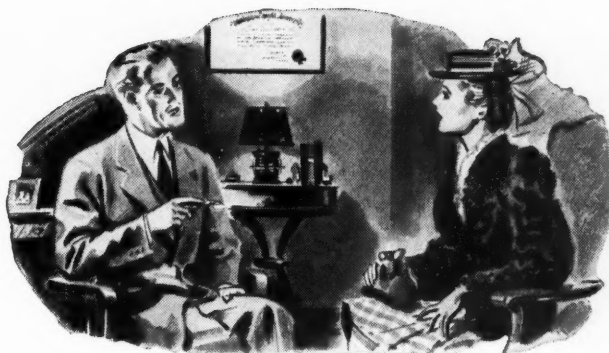
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**Q.** *But, doctor, is it all right to leave the peas I  
don't eat in an open can?*

**A.** *From the standpoint of health, there is no  
reason why peas, or any canned food, should  
be put into another container. (1)*

(1) For some obscure reason many members of the general public persist in believing that an open can is not a safe food container. The U. S. Department of Agriculture expressed itself on this fallacy in a press release of February 23, 1936, as follows:

"... Thousands of housewives are firm in the faith that canned foods ought to be emptied as soon as the can is opened, or at least before the remainder of the food goes into the refrigerator... Whether in the original can or in another container, the principal precautions for keeping food are—Keep it cool and keep it covered." *American Can Company, 230 Park Avenue, New York, N. Y.*



The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



# Names in the News

## Administrators

DR. DONALD C. SMELZER, director of the Graduate Hospital of the University of Pennsylvania, Philadelphia, since 1930, will resign on June 1 to assume the position of managing director of Germantown Dispensary and Hospital, Philadelphia. Doctor Smelzer is a member of the editorial board of *The Modern Hospital*, a trustee of the American Hospital Association and a charter fellow and member of the board of regents of the American College of Hospital Administrators. Prior to his association with Graduate Hospital, he was superintendent of Charles T. Miller Hospital, St. Paul.

HAROLD A. SAYLES, superintendent of J. Marion Sims Memorial Hospital, Lancaster, S. C., resigned recently. Mrs. GERTRUDE T. HAYNES, R.N., who was formerly superintendent of nurses at



Columbus City Hospital, Columbus, Ga., was named successor.

JAMES RONE FELTS, administrative assistant at Charlotte, N. C., has been named head of Cabarrus County Hospital, Concord, N. C.

CHARLOTTE PIPER, R.N., formerly superintendent of Fauquier County Hospital, Warrenton, Va., has been appointed to succeed A. DOUGLAS KINCAID as head of Southside Community Hospital, Farmville, Va.

DR. TAEKE BOSCH, superintendent of Christian Sanatorium, Midland Park, N. J., will resign that position on May 1 to go into private practice in Paterson, N. J. He also expects to open a private hospital for mental patients in Ridgewood, N. J. Doctor Bosch's assistant, DR. JOHN KREMER, also tendered his resignation.

DR. OLIVER P. DALY assumed his duties as permanent superintendent of Charity Hospital, New Orleans, on March 1 on an executive order placing the hospital under the jurisdiction of the state department of institutions. DR. J. O. WEILBACHER JR., former acting director, and his assistant, DR.

CHARLES B. ODOM, will continue to serve as associate superintendents.

CATHERINE L. PERRY, R.N., for five years superintendent of the Medical Mission Dispensary in Boston, resigned recently to accept the position of superintendent of Martha's Vineyard Hospital, Oak Bluffs, Mass. Her successor at the dispensary is CAROLYN K. WINTERS, R.N.

DR. BARDWELL H. FLOWER, assistant commissioner of the Massachusetts Department of Mental Health, has been named to succeed DR. WILLIAM A. BRYAN as head of Worcester State Hospital, Worcester, Mass. Since Doctor Bryan's resignation last year, DR. WALTER E. BARTON has been acting superintendent.

FRANCES B. HYDE, superintendent of Soldiers and Sailors Memorial Hospital, Penn Yan, N. Y., for the last two years, resigned recently to be married. She will continue to serve as administrator of the hospital until her successor has been appointed.

ELLEN P. YOUNG, superintendent of nurses at Memorial Hospital, Albany, N. Y., was recently appointed head of the hospital. She succeeds THOMAS T. MURRAY, who resigned last October to become head of White Plains Hospital, White Plains, N. Y. Miss Young joined the staff of Memorial Hospital in August 1940. Prior to that she had been superin-



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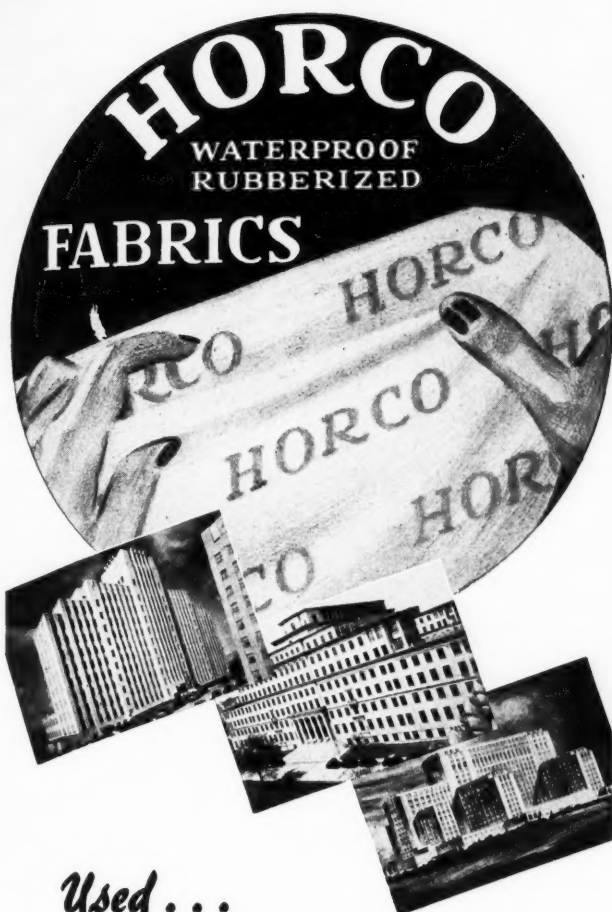


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tendent of nurses at Nashua Memorial Hospital, Nashua, N. H.

LOUISE H. THOMPSON, superintendent of Elliott Community Hospital, Keene, N. H., for the last eighteen years, has submitted her resignation to take effect on May 1. Miss Thompson's assistant, MARTHA F. VAN WERT, will also resign on that date. MABEL L. PARSONS, head of Franklin Hospital, Concord, N. H., has been selected to succeed Miss Thompson.

MARION L. JACKSON, R.N., has been named to succeed M. LOUISE SANFORD as superintendent of Addison Gilbert Hospital, Gloucester, Mass. Miss Jackson will also serve as principal of the nurses' training school. She was formerly superintendent at Winchester Hospital, Winchester, Mass.

DR. A. P. COLE has been appointed to succeed DR. MILES J. SCOTT as medical director of the Hamilton County Chronic Disease Hospital, Cincinnati.

DR. JOHN MRAS, superintendent of the Chester County Hospital for the Insane, Embreeville, Pa., resigned that position February 15.

MARY ELMA THOMPSON, superintendent of Huntington Hospital, Huntington, Ind., for more than three years, resigned recently. Prior to her association with the Huntington institution, Miss Thompson had been head of

Methodist Hospital, Princeton, Ind., for ten years.

SISTER M. SERAPHIA, superintendent, St. Agnes Hospital, Fond du Lac, Wis., has gone to Colby, Kan., where she will head the new Thomas County Hospital, now being erected at Colby. SISTER M. SEBASTIAN will succeed her.

KAPULANI MAKAHANOHANO has resigned as superintendent of Kona Hospital, Hilo, Hawaii. ESTHER ANN BARLOW will continue as acting superintendent of the new hospital until a permanent superintendent is selected by civil service examinations.

#### Department Heads

EVANGELINE O. THORNTON, R.N., has been appointed director of nurses at Stillman Hospital, Tuscaloosa, Ala., having resigned a similar position at Provident Hospital, Chicago, to accept the new position.

ANNE McKEON, R.N., was recently named superintendent of nurses and anesthetist at City Memorial Hospital, Thomasville, N. C. She succeeds Mrs. LUCILLE CRABTREE.

ALMENA WUERTHNER, R.N., formerly superintendent of nurses at Philipsburg State Hospital, Philipsburg, Pa., has accepted the appointment of director of nurses at Fairmont General Hospital, Fairmont, W. Va.

#### Deaths

KATHARINE ANNE SANBORN, founder and superintendent for forty-three years of St. Vincent's Hospital School of Nursing, New York City, died at the hospital at the age of 81. Miss Sanborn retired as superintendent of the school in 1934.

DR. CHARLES V. CHAPIN, pioneer in public health work, died January 31 at the age of 85. Doctor Chapin served as medical consultant to Rhode Island, Providence Lying-In and Butler hospitals. He was also secretary of the board of hospital commissioners of Providence City Hospital which, in 1931, was renamed the Charles V. Chapin Hospital in recognition of his services in behalf of medical science.

THE REV. PAUL WENDT, former superintendent of Evangelical Deaconess Hospital, Milwaukee, died February 18 at the age of 71. The Rev. Mr. Wendt had been head of the hospital from 1931 to 1940. He left the hospital on May 1, 1940, to accept the Evangelical pastorate at Thiensville and Richfield, Wis.

DR. CLAUDE ADELBERT BURRETT, president of New York Medical College, Flower and Fifth Avenue Hospitals, died of a cerebral hemorrhage on March 5. Doctor Burrett had been president of the college and hospitals since 1939 and before that had been dean and also medical director.

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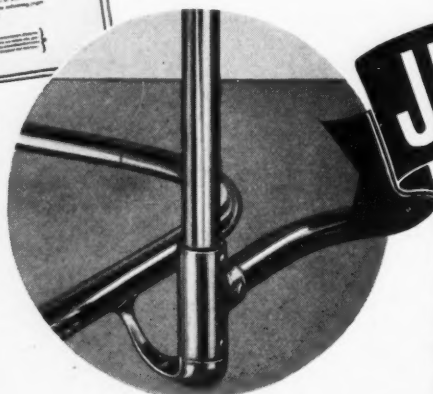


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## Books on Review

**CAREERS IN ANESTHESIA.** *Chicago: Institute for Research.* 1940. Pp. 24. Paper. \$1.

This monograph should be in the hands of everyone to whom young people choosing a professional career might come for advice. It explains in detail what the subject is, the advantages and disadvantages of such a career and exactly how one goes about making a start at it.

Medical and nursing school graduates will find its concrete and comprehensive advice of real worth when deciding upon special training. It correctly points out that while the field of anesthesiology is rapidly expanding, opportunities for nurse anesthetists are decreasing as the number of physician anesthetists increases.

The account of the history of the subject is commendable, since it ignores the existence of a controversy that is best forgotten. Specifically, the statement that carbon dioxide is an anesthetic agent in practical use today must be criticized as a misinterpretation of the therapeutic use of that gas.—RALPH M. WATERS, M.D.

**1940 YEAR BOOK OF PUBLIC HEALTH.** By J. D. Geiger, M.D. *Chicago: Year Book Publishers.* 1940. Pp. 545. \$3.

The addition of a year book of public health to the series embracing other branches of medicine strongly indicates the constantly increasing interest in this field and the desire of those seeking information for condensed, authoritative, time-saving material.

The subjects covered in this book are diversified and include 421 carefully summarized articles on public health administration, the communicable diseases and epidemiology, food and milk, nutrition, housing, laboratory procedures, industrial hygiene and vital statistics.

Timely features are articles that deal with the varied aspects of military and naval hygiene. Among the other subjects receiving the consideration their importance warrants are tuberculosis and the venereal diseases.

This book makes available to everyone who is interested in the field of public health varied current literature on the subject contributed by leaders in America and abroad, together with brief and

frank editorial comment by an eminent worker in this field. It should prove of particular value to public health workers, members of the medical profession, teachers and others concerned with individual and community health.—CHARLES F. WILINSKY, M.D.

**FEEDING THE FAMILY.** By Mary Swartz Rose. *Fourth Edition.* New York: The Macmillan Co. 1940. Pp. 421. \$5.

This book has been a standard text for almost a quarter of a century and is so well known that this fourth edition will be heartily welcomed by home economists everywhere. It is just as helpful as the previous editions and it makes the science of nutrition even more vital.

Much of the material in Mrs. Rose's books is based on her own experience and investigations made under her direction for many years. She was familiar with the nutrition needs of persons of all ages from early childhood to old age. She tells the hows and whys of foods and their application in improving health and in treating sickness in the family. Every phase of the subject is discussed and there are many full page illustrations of foods. Emphasis is given to the importance of vitamins and minerals in the development of the child and to routine use of foods that are good sources of these nutrients.—LULU G. GRAVES.



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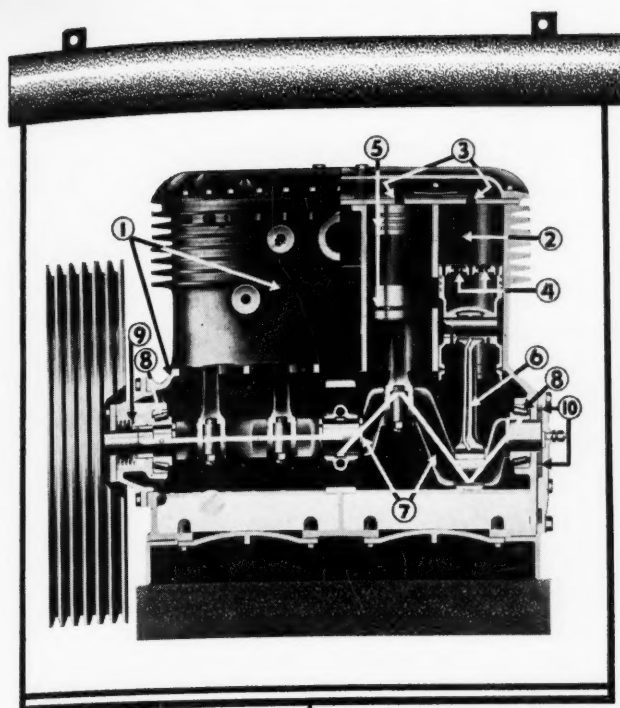
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## Reader Opinion

Thanks for the "Forum"

Sirs:

I want to express my appreciation for the "Small Hospital Forum." It certainly has been most interesting as well as helpful to me.

Martiel Sharpe, R.N.,  
Superintendent.

Rutherford Hospital,  
Murfreesboro, Tenn.

### Intern Appointments

Sirs:

I have just been reading the editorial on "Intern Appointments" in the February issue (see page 45) and feel I must say a word about this question. We have a two year internship and appoint six men each year. Two years ago when the request came that we join in making our appointments on November 15, I was glad to comply with the request. Of course, we had a great many applications during the summer and early fall. We made our choice from among these applicants but withheld appointments until November 15.

When we sent out the appointments, lo and behold! five of the good men we had selected had already accepted appointments in other hospitals! I was left holding the bag and had to take what I could get. I cannot run a hospital that way. So this year I promptly began the appointment of interns as soon as we got what we considered a first-class applicant.

I agree with you that it is too bad that the hospitals and medical schools cannot cooperate any better than that.

Sidney G. Davidson,  
Administrator.

Grace Hospital,  
New Haven, Conn.

Hospitals and medical schools in the United States might profitably study the operations of the Canadian Intern Board, which are fully described in the February issue of the *Canadian Hospital*. This board, which is composed of representatives of the interns and the hospitals, with a close link to the Canadian Medical Association, receives from the senior medical students a list of hospi-

tals to which they have made application for internship. This list is arranged on a preferential basis. The hospitals, in turn, notify the board of the applicants whom they wish to accept and also append a list of alternates. The board then goes over the lists and allocates to the hospitals their first choice of interns insofar as that is possible.

After this allocation some hospitals will not have filled their quotas and some prospective interns will not be assigned. The hospitals are then given a list of unassigned interns and the prospective interns are given a list of hospitals with openings. Most of the remaining students soon find places.

For the current year, 80 per cent of the interns were placed in the hospital of their first choice; 10 per cent, in the hospital of second choice, and 7 per cent, in the institution they rated third. Only 3 per cent had to accept positions in institutions that placed fourth, fifth or sixth on their lists. The board does not attempt to control or direct the placement of interns but rather to facilitate it on an orderly basis for the benefit of the medical students and the cooperating hospitals. While the problem in the United States is more complicated, owing to the larger numbers involved, some solution along these lines might be helpful.—Ed.



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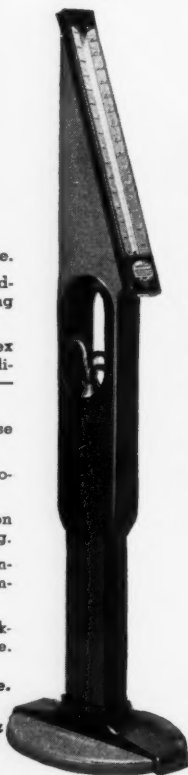
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